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**TELLING STORIES:  
PERSONAL NARRATIVE AS A CONSTRUCTION OF RECOVERY  
PROCESSES FOLLOWING PSYCHOSIS  
& CLINICAL RESEARCH PORTFOLIO**

**VOLUME I**

(Volume II bound separately)

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July 2010

Submitted in partial fulfilment of requirements for the Degree of  
Doctorate in Clinical Psychology

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**VOLUME I**  
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# **CHAPTER 1**

## **SYSTEMATIC REVIEW**

### **Coding Metacognition in the Discourse of Individuals Diagnosed with Psychosis: A Systematic Review**

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July 2010

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*Prepared according to submission guidelines for Clinical Psychology Review (Appendix 1.1)*

## **Abstract**

**Background:** Metacognition is described as the awareness and understanding of mental states underpinning social behaviours. There is increasing interest in metacognition in psychosis, as symptoms imply impaired metacognition. Lab-based tests of metacognition have been criticised for limited ecological validity. Recent research has focused on metacognition in discourse about self and experiences. **Aims:** This review aimed to consider how metacognition has been coded in the discourse of individuals with psychosis, report results, and consider methodological issues. **Method:** Computerised literature search, consultation of experts and hand search of a key journal were implemented. Reference sections were hand searched for further relevant literature. Articles were screened for inclusion by scrutiny of abstract and methodology. Findings were synthesised and papers subjected to methodological critique. **Results:** Six papers were included, each demonstrating methodological strengths and limitations. Two measures had been used to code metacognition. Metacognition was compromised in participants with psychosis, with varied impairment across sub-functions. Associations were observed between metacognition and symptom profile, neurocognition, self-experience, awareness, social cognition, and recovery of function. **Applications:** Assessing metacognition may offer clinicians information to optimise formulation and intervention. A need for interventions aimed at enhancing metacognitive capacity was highlighted. These may improve psychosocial functioning, e.g. vocationally, offering benefits to individuals and wider society.

## **Keywords**

Metacognition, Mentalization, Theory of Mind, Psychosis, Discourse, Narrative

## Introduction

### *Defining Metacognition*

‘Theory of mind’ (ToM) was first used by Premack and Woodruff (1978), to describe the capacity to make inferences about the mental states of oneself and others. Frith, Leslie and Morton (1991) called this inferential process ‘mentalising’. The concept of ‘mentalisation’ has been used to describe an awareness and understanding of mental states - in oneself and others - that underpin social behaviours. It has been proposed that mentalisation is the means by which humans understand their social world (Fonagy, 1991; Fonagy, Gergely, Jurist & Target, 2002; Bateman & Fonagy, 2004). Borrowing from psychoanalytical, developmental and neurocognitive psychologies, Fonagy developed a theory of mentalisation as a developmentally achieved capacity, and posited that deviations from ‘normal’ developmental pathways may lead to psychopathologies in adulthood. The term ‘metacognition’ has also been used to describe *‘the capacities to understand mental phenomena, to think about one’s own thinking and the thinking of others, and to use that understanding to problem solve and master mental states’* (Dimaggio *et al.*, 2007, p386-387). Metacognition has been operationalised using the Metacognitive Assessment Scale (MAS), devised by Semerari *et al.* (2003) which rates metacognitive skills as they are revealed through an individual’s verbalisations. The focus of the scale is *not* on the content of speech, but on whether or not an individual makes use of various metacognitive sub-functions within discourse. In developing the scale, the authors were informed by literature on mentalisation and attachment theory (Fonagy, Gergely, Jurist & Target, 2002; Main, 1991), theory of mind (ToM; Baron-Cohen, Leslie & Frith, 1985), metacognition (Flavell, 1979) and metarepresentation (Sperber, 2000). An abbreviated version of the MAS has latterly been developed by Lysaker, Carcione *et al.* (2005).

Given the different emerging definitions to describe metacognition, as detailed above, it has been challenging for researchers to reach a consensus about how to define and operationalise the concept, and this has led to conceptual blurring and variable definitions in the literature. Even those espousing the concept have acknowledged the challenges posed by the wide conceptual breadth of mentalisation (Allen, 2006). Attempts have been made to clarify the concept, exploring its overlaps with ‘conceptual cousins’ such as empathy, insight and imagination (c.f. Allen, 2006; Choi-Kain & Gunderson, 2007). There has been a tendency in the literature to use terms such as ‘mentalisation’, ‘metacognition’ and ‘theory of mind’ interchangeably (Lysaker, Dimaggio, Buck, Carcione and Nicolò, 2007). While this implies a singular aptitude, Lysaker, Dimaggio *et al.* (2007) argue that metacognition actually encompasses a range of semi-



independent faculties, which overlap - but are not synonymous - with other concepts, such as 'insight'.

Theorists differ in their understanding of the development and maintenance of metacognitive capacity. Some researchers have suggested that disorganisation of early attachment can lead to an internal working model that acts to impair metacognition (Prunetti *et al.*, 2008). Others have linked metacognition with aspects of neurocognition, such as executive function (Lysaker, Warman *et al.*, 2008). The concept has been applied across a number of clinical domains, including the treatment of individuals with a diagnosis of borderline personality disorder, eating disorders and high-risk parent-infant dyads (Choi-Kain & Gunderson, 2008). It has even been suggested that the success of all effective therapies is rooted in the fundamental mechanism of mentalisation (Allen, Fonagy & Bateman, 2008).

### *Metacognition and Personality Disorder*

Much of the literature on metacognition thus far has focused on individuals diagnosed with personality disorder. Dimaggio *et al.* (2007) noted deficits or 'malfunctions' in metacognition in such individuals, and proposed that differential patterns of impairment amongst sub-functions of metacognition may distinguish the different personality disorders. This, they argued, has implications for therapeutic work with such individuals, potentially providing clear foci for the work of the mental health clinician. Metacognitive Interpersonal Therapy (MIT: Dimaggio & Semerari, 2003; Dimaggio, Semerari, Carcione, Nicolò & Procacci, 2007) is based on the premise that if personality disorders are characterised by deficits in metacognition, then therapy should aim to improve metacognitive skills. It is proposed that individuals with personality disorder are unable to forge a therapeutic alliance or set goals for treatment, due to metacognitive deficits (e.g. understanding the motivations of others). MIT focuses on improving metacognition, initially within the therapeutic relationship and subsequently in the wider social arena. Bateman and Fonagy (2004) also developed a therapeutic programme called 'mentalisation-based treatment', designed to enhance skills in mentalisation. Randomised controlled trials have provided empirical validation for the treatment's efficacy over non-specialised psychiatric treatment, with gains sustained at follow-up over a number of years (Bateman & Fonagy, 1999, 2001, 2008).

## *Metacognition and Schizophrenia*

In recent years, there has been a growing interest in exploring metacognition in individuals diagnosed with schizophrenia. Many of the symptoms associated with schizophrenia spectrum disorders, such as paranoia or delusional beliefs, involve failure to reflect upon and understand the mental states of oneself and other people. For example, Amador *et al.* (1994) found that many individuals with a diagnosis of schizophrenia seem to lack awareness of their difficulties. Research has produced consistent evidence of metacognitive impairments in individuals with schizophrenia, to the extent that some have suggested that this should feature in diagnostic criteria (Bell, Langdon, Siegert & Ellis, 2010). There is evidence of an association between levels of psychopathology and deficits in metacognition (Lysaker, Dimaggio *et al.*, 2007). It has further been hypothesised that metacognitive impairments may be associated with poor treatment outcomes (Lysaker, Warman *et al.*, 2008). Supporting this, associations have been observed between impairments of mentalisation/metacognition and impairments in social and interpersonal functioning in individuals with a diagnosis of schizophrenia (Schaub, Abdel-Hamid & Brüne, 2010).

## *Measuring Metacognition in Schizophrenia*

Different perspectives on metacognition have led to different approaches to researching the phenomenon, including modes of measurement. As metacognitive impairments appear to be so pertinent to working with individuals with schizophrenia spectrum disorders, it has been predicted that assessment of such capacities will soon become a standard pre-cursor to treatment (Bell *et al.*, 2010). As such, there is growing interest in how best to measure metacognition in individuals with schizophrenia. Broadly speaking, metacognition has been explored principally using lab-based tests and narrative-based approaches.

The majority of tests developed thus far have been lab-based, and have therefore been open to criticism for their limited ecological validity (Gumley, 2010). Bell *et al.* (2010) differentiate between ‘social-cognitive ToM tasks’, such as understanding irony and metaphor or appreciating visual jokes, ‘social-perceptual ToM tasks’, such as inferring mental states from eye expressions, and ‘real-world and more ecologically valid ToM assessments’ such as structured interview and conversation analysis. Given the importance of mentalisation/metacognitive capacities in successful navigation of daily life and the interpersonal world, there is an argument that the latter measures are best able to capture how individuals use these faculties in the real world. Discourse-and narrative-based approaches may

represent an ecologically valid means of examining how individuals make use of metacognitive processes in discussing their experiences. To the author's knowledge, there is no existing review of the use of such approaches with individuals who have diagnoses of psychosis.

### *Aims*

This paper aims to explore and evaluate how metacognition has been coded in the discourse of individuals with psychosis.

### *Objectives*

1. To explore the measures and methods used to code metacognition in the discourse of individuals with psychosis;
2. To synthesise and discuss the key findings regarding metacognition in the discourse of individuals with psychosis;
3. To consider the quality of published research in which metacognition has been coded in the discourse of individuals with psychosis.

### **Method**

The review was conducted in two phases. The first phase involved searching and screening the literature for relevance and quality. The second phase focused on analysing and synthesising the evidence.

#### Phase 1

##### *Establishing Search String and Computerised Literature Search*

A search string was derived in order to conduct a systematic search of published literature. A comprehensive list of key words was compiled, based on relevant literature. There were four main components to the search string: metacognition, coding, psychosis and mental illness, and discourse. The search string was piloted, and further terms added until sufficient scope was attained.

### *Final Search String*

1. Metacogniti\$ OR reflexiv\$ OR (reflective function\$) OR mentalis\$ OR mentaliz\$ OR (theory of mind) OR reflective\$
2. Code OR coding OR categor\$ OR scor\$ or measur\$ OR system\$ OR analy\$ OR scale
3. Psychosis OR psychotic OR schizo\$ OR (mental illness) OR (mental health problem) OR (mental health difficulty) OR (mental health disorder) OR (personality disord\$) OR psychiatric
4. Discourse OR narrative\$ OR interview\$ OR account\$ OR apprais\$ OR story OR stories OR interpret\$ OR transcript\$

Truncation (\$) was used to maximise search sensitivity. Key words within each component were combined using the Boolean operator ‘OR’ and the four components were combined using ‘AND’. The following limits were applied to focus the output of the search:

- Language: English language papers.
- Date: papers published after 1989.
- Type of citation: abstract available.

The search was conducted using five databases hosted by Ovid: Ovid Medline, EMBASE, PsycINFO, the British Nursing Index and Archive, and EBM Reviews – the Cochrane Database of Systematic Reviews. In order to test the sensitivity of the search string, the reference section of each paper identified was searched for further potentially relevant papers. An expert in the field was consulted to ensure that no key papers had been overlooked. A key journal, *Clinical Psychology & Psychotherapy*, was searched by hand.

### *Screening for Relevance and Inclusion*

Articles were subjected to the following screening process: abstracts were reviewed for inclusion criteria, proceeding to scrutiny of the methodology section where sufficient information could not be obtained. Inclusion and exclusion criteria were as follows:

#### **Inclusion Criteria:**

- Adult sample (aged 18 and over)
- Individuals with experience of psychosis

- Investigating metacognition as manifested in participants' discourse
- English language papers
- Papers published in or after 1989
- Peer-reviewed papers

#### Exclusion Criteria:

- Case studies
- Unpublished studies
- Reviews, conference abstracts, book chapters, unpublished dissertations
- Studies which did not focus exclusively on individuals with experience of psychosis

These criteria were developed to ensure that the review was finely focused, i.e. on the measurement of metacognition in the discourse of adults with psychosis, and to eliminate irrelevant studies. The principal reviewer carried out the screening process, consulting with a research advisor in cases where there was any doubt about an article meeting inclusion criteria. All articles that did not meet inclusion criteria were discarded. Where inclusion criteria were met, the paper progressed to the next stage of review.

#### Phase 2

##### *Analysis of Quality*

Analysis of the quality of papers was informed by the Scottish Intercollegiate Guidelines Network guidelines for assessing the quality of cohort studies (SIGN, 2004), the Clinical Trial Assessment Measure (CTAM; Tarrier & Wykes, 2004), and the Consolidated Standards of Reporting Trials Statement (CONSORT; CONSORT Group, 2010).

##### *Synthesis of Data*

Key findings were collated, compared and synthesised according to areas of interest to this review.

## Results

The process by which studies were identified is summarised in Figure 1. The initial database search yielded 178 results. Based on information contained in abstract sections, 19 of these studies were thought to be potentially relevant to the focus of this review. Four articles were sourced from a hand search of the key journal *Clinical Psychology & Psychotherapy*, and one from an expert in the field. Hand searching the reference sections of these 24 articles identified 40 potentially relevant papers based on titles, which was then reduced to three articles through abstract review. Thus, 27 articles proceeded to the next stage of relevance screening. Scrutiny of the method sections of these articles revealed that a total of 6 met inclusion criteria for this review, four from the initial database search, one from hand search of reference sections, and one from an expert in the field.

INSERT FIGURE 1 ABOUT HERE

A summary of the papers included in the review is provided in Table 1. Salient characteristics of the studies will be summarised, and the main findings of the review will be presented. Methodological issues will then be considered.

INSERT TABLE 1 ABOUT HERE

### *Sample Characteristics*

Six studies met inclusion criteria. These included a total of 308 participants with psychosis, of whom 274 were male and 34 were female. Bosco *et al.* (2009) also included 22 gender and age-matched control subjects. The mean age of participants ranged from 39.59 to 49.63 years, with a median of 47.62. All participants had diagnoses of schizophrenia spectrum disorders (schizophrenia or schizoaffective disorder), established using the Diagnostic and Statistical Manual 4<sup>th</sup> Edition (DSM-IV; American Psychiatric Association, 2000). All studies reported that participants were exclusively in a post-acute or chronic phase of psychosis. Studies by Lysaker and colleagues defined ‘post-acute’ as meaning no hospitalisations or changes to medication or housing in the month preceding participation, except Lysaker, Warman *et al.* (2008) which specified only no hospitalisations or changes to medication. Bosco *et al.* (2009) did not define ‘chronic phase’.

### *Measure Characteristics*

As this review investigates how metacognition has been coded in discourse, the means of data collection and assessment are of particular interest. All six studies in the review used specified interviews to yield participant discourse, and explored metacognition therein.

The majority of studies included in the review (n=5; all studies by Lysaker and colleagues) were conducted by one group using two measures to examine metacognition: the Indiana Psychiatric Illness Interview (IPII; Lysaker, Clements, Plascak-Hallberg, Knipscheer & Wright, 2002) and the Metacognition Assessment Scale (MAS; Lysaker, Carcione *et al.*, 2005; Semerari *et al.*, 2003). The IPII is a semi-structured interview designed to produce a narrative of self and psychiatric experiences. The interview is divided conceptually in to sections: establishing rapport and asking the participant to tell his life story in as much detail as possible; asking whether the participant thinks he has a mental illness, and how he understands it; asking about how the participant's condition has affected him interpersonally and psychologically; asking whether and how the participant's condition 'controls' his life, and how he 'controls' his condition; and asking what the participant expects to be the same and to be different in future, both interpersonally and psychologically. Further questions of interest may be added to the interview according to the aims and hypotheses of the study, e.g. Lysaker, Dimaggio *et al.* (2007) and Lysaker *et al.* (In Press) added questions about how much the participant's 'illness' had been affected by others and how much others had been affected by the 'illness', to provide further opportunity for participants to represent others as having alternative and separate perspectives and motives to themselves.

As aforementioned, the Metacognitive Assessment Scale (MAS) was devised by Semerari *et al.* (2003) to rate metacognitive skills as manifested in discourse during psychotherapy. Lysaker and colleagues subsequently consulted with the original authors to abbreviate and adapt the scale for use with IPII transcripts (Lysaker, Carcione *et al.*, 2005; Lysaker, Davis *et al.*, 2005). The scale explores four sub-functions of metacognition: 'understanding one's own mind' (the capacity to distinguish, recognise, define and integrate one's own states of mind, e.g. thoughts, memories and emotions), 'understanding others' minds' (the capacity to comprehend the mental states of others in the aforementioned manner), 'mastery': *'the ability to work through one's representations and mental states, with a view to implementing effective action strategies, in order to accomplish cognitive tasks or cope with problematic mental states'* (Semerari *et al.*, 2003, p244) and 'decentration', or the ability to understand that others have unique perspectives and independent motives from oneself. Each sub-function measured by the MAS is divided in

to a series of aptitudes or capacities, with points awarded according to how fully that capacity is established in the narrative transcript. Aptitudes are listed in hierarchical order, so that failure to demonstrate a capacity earlier in the list precludes the attainment of higher capacities (e.g. if the participant does not recognise emotions, he or she should not be able to understand links between thoughts and emotions). All five studies by the Lysaker group provided an analysis of inter-rater reliability (details provided forthwith); however, none provided details of test/re-test reliability. The papers collectively contributed to evidence regarding convergent and divergent validity for the MAS by demonstrating associations with other measures.

Bosco *et al.* (2009) used the Theory of Mind Assessment Scale (Th.o.m.a.s.), a semi-structured interview, which aims to assess a participant's theory of mind. The Th.o.m.a.s. consists of 39 questions, organised along four scales: knowledge of own mental states (I-Me), knowledge of others' mental states as being independent of one's own (Other-Self), knowledge of the mental states of others (Me-Other), and knowledge of others' perspectives about one's own mental states (Other-Me). Each of these scales is further divided into sub-scales of 'awareness', or the ability to perceive and differentiate mental states in oneself and others; 'relation', or the ability to recognise causal relationships between mental states and behaviour; and 'realisation', or the ability to adopt effective strategies to achieve a desired state. Questions focus on epistemic states (knowledge, beliefs, etc.), volitional states (desires, intentions, etc.), positive and negative emotions. They are open-ended, allowing spontaneous expression, and prompts may be used to enrich and contextualise answers. Information about inter-rater reliability of the Th.o.m.a.s. was provided for the Bosco *et al.* (2009) study, but test/re-test reliability was not addressed. The authors found a significant correlation between standard ToM tests and overall Th.o.m.a.s. score, as well as three of the sub-scales, providing some support for the validity of the measure. Although there was no correlation with the Other-Me scale, the authors pointed out that this second-order ToM was not specifically investigated by the standard ToM tests used in the study.

In spite of differing terminologies, there was overlap between the metacognitive capacities studied by Bosco *et al.* (2009) and the Lysaker group. For example, the Th.o.m.a.s. adopts language such as 'first and third person perspectives', while the MAS explores 'understanding of one's own mind and the minds of others'. In the synthesis of results presented below, a shared language is established that recognises the parallels between concepts studied.



## Key Findings

### *The Phenomenology of Metacognition in Psychosis*

Across the studies included in this review, results suggested that individuals with schizophrenia spectrum disorders experience compromised metacognitive functioning. Only one study (Bosco *et al.*, 2009) compared individuals diagnosed with schizophrenia spectrum disorders with a group of non-psychiatric control subjects. As anticipated, they found that participants with these diagnoses showed impaired metacognition both globally and across all specific scales, sub-scales and types of mental state investigated by the Th.o.m.a.s. In other words, participants with schizophrenia spectrum disorders showed lesser awareness of their own and others' mental states, of others having independent and unique perspectives, and of others having a perspective on their (the participants') mental states. Furthermore, participants with these diagnoses demonstrated less ability to perceive and distinguish different mental states, to recognise causal links between mental states and behaviours, and to implement strategies to achieve a desired state. Finally, their performance was inferior to that of controls across the different types of mental state in question: beliefs, desires, positive emotions and negative emotions.

In samples composed purely of individuals with diagnoses of schizophrenia spectrum disorders, metacognitive difficulties remained apparent. Lysaker, Dimaggio *et al.* (2007) found that many participants demonstrated significant 'deficits' in at least two semi-independent sub-functions of metacognition. Of their sample, 85% showed impaired capacity to see the world in a decentred manner (i.e. recognising others as having motives independent to oneself), and a further 37% of that group had an additional impairment in recognising and distinguishing their own feelings. Only 15% of 69 participants showed preservation of these abilities. This 15% achieved higher scores on the 'understanding one's own mind' scale of the MAS compared with both other groups (those with impaired decentration and those with dual impairments).

Exploration of different capacities enabled a depiction of 'metacognitive profiles' in individuals with schizophrenia spectrum disorders, and consideration of whether there were areas of relative strength or difficulty within the overarching territory of metacognition. In line with hypotheses, Bosco *et al.* (2009) found that participants with a diagnosis of schizophrenia were, on average, better able to reason about their own mental states than those of others. They were also significantly better able to understand a character's beliefs about the state of the world (first order inference) than to understand a character's beliefs about another character's beliefs (second order inference). Their performance on tasks did not vary significantly according to

whether the mental states of others were represented in relation to the self (egocentric representation) or independently of the self (allocentric representation). Finally, participants with schizophrenia showed better ability to perceive and differentiate different mental states than to recognise causal relationships between mental states and behaviours. This suggests that some aspects of metacognition are better preserved than others in individuals with schizophrenia spectrum disorders.

### *Metacognition and Symptom Profile*

Some studies examined the relationship between metacognition and symptomatology in individuals with schizophrenia spectrum disorders (Bosco *et al.*, 2009; Lysaker, Carcione *et al.*, 2005; Lysaker, Dimaggio *et al.*, 2007) using the Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein & Opler, 1987) to assess symptom profiles. Bosco *et al.* (2009) found that participants with schizophrenia who showed better overall metacognition scored significantly lower on the PANSS for positive and negative symptoms and general psychopathology. Higher scores for negative symptoms were associated with impairments across all metacognitive capacities (awareness of own and others' mental states, of others having independent perspectives, and of others having a perspective on one's own mental states). Higher scores for positive symptoms were correlated only with awareness of own and others' mental states, and higher levels of general psychopathology were correlated with lesser awareness of own and others' mental states and of others having independent perspectives. This suggests that individuals with predominantly negative symptoms may experience greater impairments in metacognition than those with predominantly positive symptoms or general psychopathology.

Lysaker, Carcione *et al.* (2005) demonstrated that, in individuals with schizophrenia and schizoaffective disorder, a negative symptom measured by the PANSS - emotional withdrawal - was correlated with understanding one's own mind and others' minds, and with mastery. In terms of positive symptoms, suspiciousness correlated only with mastery, while hallucinations correlated with understanding one's own mind at the level of a trend. Depressed mood (described as a general symptom) was linked to impaired understanding of one's own mind. These results support the Bosco *et al.* (2009) conclusion that individuals with prevailing negative symptoms experience more severely impaired metacognition.

The results detailed above were further supported by Lysaker, Dimaggio *et al.* (2007), who categorised participants according to whether or not they could recognise and distinguish their

own thoughts and feelings, or see the world in a decentred manner. They found that participants with minimal self-reflectivity and impairments in decentration showed significantly more severe negative symptomatology than participants with basic self-reflectivity but impaired decentration, but not participants with basic self-reflectivity and preserved decentration. Groups did not, however, vary across positive symptoms. The minimal self-reflectivity, non-decentred group scored higher for symptoms of disorganisation on the PANSS than participants with basic self-reflectivity (with or without impairments in decentration), but showed significantly *lower* levels of emotional discomfort than participants who demonstrated both basic self-reflectivity and decentration. This suggests that better preserved metacognition, specifically greater awareness of one's own mind and the ability to understand that others have unique perspectives and independent motives, is associated with greater emotional pain.

### *Metacognition and Neurocognition*

Neuropsychology refers to the study of how the structure and function of the brain are linked to psychological processes such as perceiving, processing and retaining information. Neuropsychological tests are designed to shed light on specific cognitive processes, which may be linked to the functioning of particular neural pathways in the brain. Bosco *et al.* (2009) found that IQ in participants with schizophrenia, measured with the Wechsler Adult Intelligence Scale, Revised (WAIS-R; Wechsler, 1981), was positively correlated with overall metacognitive capacity and with all sub-scales except knowledge of one's own mental states. The authors suggested that the absence of an association between this sub-scale and IQ might be explained by this being 'the easiest' metacognitive sub-function measured by the Th.o.m.a.s. Lysaker, Dimaggio *et al.* (2007) showed that participants with basic self-reflectivity demonstrated greater pre-morbid intelligence and non-verbal intelligence on sub-tests of the Wechsler Adult Intelligence Scale, 3<sup>rd</sup> Edition (WAIS-III; Wechsler, 1997) than those with minimal self-reflectivity. Thus, higher IQ appears to be associated with better preserved metacognition.

The cognitive processes explored by neuropsychological tests were referred to in the current papers as 'neurocognition'. Like metacognition, neurocognition was conceptualised as having numerous sub-functions, with the potential for varying correlations between their respective domains. Exploring associations between metacognition and 'multiple domains of neurocognition', Lysaker, Dimaggio *et al.* (2007) showed that participants with deficits in the metacognitive functions of self-reflectiveness and decentration achieved lower scores in seven of 10 neuropsychological tests compared with participants who had neither deficit, and in four tests compared with participants with a deficit in one of the areas. This implies a proportional

relationship between level of impairment in neurocognitive functioning and level of impairment in metacognitive functioning. However, participants with preserved self-reflectivity and decentration performed better on only one test compared with those who demonstrated a deficit in decentration only, which perhaps implies that self-reflectivity is more closely linked with neurocognitive functioning.

Lysaker, Carcione *et al.* (2005) found that participants' performance on three MAS indices - understanding one's own mind (measuring the capacity to distinguish, recognise, define and integrate one's own states of mind, e.g. thoughts, memories and emotions), understanding others' minds (measuring the ability to comprehend other individuals' mental states as previously described) and 'mastery' - was related to verbal memory. Three other domains - premorbid intellectual functioning, visuo-motor processing speed and visuo-spatial problem solving - were found to be exclusively associated with understanding one's own mind. When entered in to a regression, the tests used to measure premorbid intelligence and visuo-motor processing speed ('vocabulary' and 'digit symbol' sub-tests of the WAIS-III; Wechsler, 1997) were able to predict a quarter of the variance in understanding of one's own mind. These results suggest that understanding of one's own mind may be influenced both by cognitive risk factors for, and outcomes of, schizophrenia spectrum disorders.

Lysaker, Dimaggio *et al.* (2007) reported that participants who showed greater ability to understand their own minds also showed better performance on tests of working memory, premorbid intellectual functioning and non-verbal intelligence ('arithmetic', 'vocabulary' and 'block design' sub-tests, WAIS-III; Wechsler, 1997), and on tests of visuo-spatial memory ('visual reproduction' sub-test of the Wechsler Memory Scale, 3<sup>rd</sup> Edition: WMS-III, Wechsler, 1997b). This group also made fewer perseverative responses and were better able to grasp, hold and shift between ideas on the Wisconsin Card Sorting Test (WCST; Heaton, Chelune, Talley, Key & Curtiss, 1993). These results indicate that difficulties experienced by individuals with schizophrenia spectrum disorders, such as distinguishing one's own mental states, are associated with impairments in executive functioning, such as difficulty retaining and reflecting upon complex, abstract information. Participants who were able to see the world in a decentred manner showed better performance on a test of visuo-spatial memory compared with individuals who were not decentred. This difference was robust, irrespective of whether or not non-decentred participants had achieved basic self-reflectivity. This seemed to highlight the importance of visual memory in seeing others as having independent perspectives, a capacity which the authors proposed may depend upon representing the social world spatially.

Lysaker, Warman *et al.* (2008) explored associations between metacognition and multiple areas of executive function, using sub-tests of the Delis Kaplan Executive Function System (DKEFS; Delis, Kaplan & Kramer, 2001). They hypothesised that overall level of metacognition would be associated with performance on tests of inhibition (the capacity to deliberately inhibit thoughts/feelings and to shift attention in a goal-directed manner) and mental flexibility (the capacity to formulate and reformulate notions of how stimuli are related, in a goal-directed manner). As expected, they found that greater understanding of one's own mind was linked to better performance on all tests of mental flexibility. Participants with higher levels of decentration - the ability to see other people as having independent perceptions and motives - achieved significantly higher scores on two tests of inhibition and one of mental flexibility. Greater understanding of others' minds and mastery were each linked to one test of mental flexibility and one test of inhibition. In keeping with previous findings by Lysaker, Buck and Ringer (2007), these findings suggest that mental flexibility is most closely linked to the metacognitive function of self-reflectivity. Tests of ability to inhibit responses were most closely linked with the faculty of decentration. The authors suggested that inability to inhibit one's thoughts may lead to preoccupation with one's own needs to the exclusion of considering others.

In summary, these results provide evidence of multiple associations between performance on neuropsychological tests and metacognition. In general, greater metacognitive capacity - as manifested in discourse - was linked to better performance on neuropsychological tests.

#### *Metacognition, Self-Experience, Awareness and Social Cognition*

In terms of how metacognition was related to social cognition, Lysaker, Carcione *et al.* (2005) found, as predicted, that greater mastery - working through one's thoughts and feelings to effectuate goal-directed behaviours - was associated with higher scores on the Quality of Life Scale (QOL; Heinrichs, Hanlon & Carpenter, 1984). This scale is a general measure of psychosocial functioning, and considers interpersonal relationships, vocational function and community involvement. Wondering about the relationship between metacognition and ability to infer emotional states in others, Lysaker, Dimaggio *et al.* (2007) showed participants videos of acted vignettes, requiring them to identify the depicted emotions (the Bell-Lysaker Emotional Recognition Test: BLERT; Bell, Bryson & Lysaker, 1997; Bryson, Bell, Lysaker, Greig & Kaplan, 1997). Better recognition of negative emotions in others was associated with higher levels of understanding one's own mind and ability to see the world in a decentred manner. Understanding one's own mind seemed especially salient: those with basic levels of self-

reflectivity were significantly better able to infer negative emotions than were those with minimal self-reflectivity, regardless of whether or not the capacity for decentration was demonstrated. Thus, better preserved metacognitive faculties were associated with greater understanding of emotions in others, and higher levels of psychosocial functioning.

Using the Scale to Assess Unawareness of Mental Disorder (SUMD; Amador *et al.*, 1994), Lysaker, Carcione *et al.* (2005) found an association between participants' awareness of their condition and mastery, independent of neuropsychological covariates. In a later study, Lysaker, Warman *et al.* (2008) used an alternative measure of insight: the Beck Cognitive Insight Scale (BCIS; Beck, Baruch, Balter, Steer & Warman, 2004), and again found correlations with metacognition. Higher levels of insight on the BCIS were linked with greater levels of understanding one's own mind on the MAS. This highlights the pre-identified overlap between constructs such as 'insight' and 'awareness of illness' with aspects of metacognition, and suggests that impaired metacognition is associated with less insight or awareness of one's psychiatric condition.

Lysaker, Buck *et al.* (2008) were interested in possible correlates between self-experience, metacognition and internalised stigma. They hypothesised that higher levels of metacognitive capacity and lower levels of stigma would be associated with greater narrative self-experience (*'the degree to which they coherently and meaningfully experience themselves as unique individuals with a sense of purpose and value'*, p.32). Self-experience was measured using the Scale to Assess Narrative Development (STAND; Lysaker, Lancaster & Lysaker, 2003), while stigma was assessed using the Internalised Stigma of Mental Illness Scale (ISMIS; Ritsher, Otilingham & Grajales, 2003). The authors also used the SUMD (Amador *et al.*, 1994) and the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) to consider participants' insight into their difficulties, and need to obtain approval by responding in a culturally approved manner. Results indicated significant associations between greater self-experience, better metacognitive capacity, and lower internalised stigma. In other words, participants with impaired capacity to think about and reflect upon their mental states and those of others, and who endorsed negative stereotypes of mental illness, constructed more impoverished narratives about their experiences of mental illness. These correlations remained when insight and socially desirable responding were controlled for. In keeping with Lysaker, Carcione *et al.* (2005), the study found that mastery was correlated with all sub-scales on the STAND: social worth, social alienation, personal agency and illness conception. Understanding one's own mind was linked with social alienation and illness awareness, while understanding others' minds was linked with alienation.

### *Metacognition and Recovery of Function*

Prior to starting a six-month work placement, participants were categorised by Lysaker *et al.* (In Press) as showing low, medium or high self-reflectivity, based on the ‘awareness of one’s own mind’ sub-scale of the MAS. Work performance was measured using the Work Behaviour Inventory (WBI; Bryson, Bell, Lysaker & Zito, 1997), designed to assess work behaviours in individuals with severe and enduring mental health difficulties. As hypothesised, participants with high self-reflectivity showed better overall work performance than those in the low and medium groups. A significant interaction suggested that the high self-reflectivity group improved quicker and sustained gains more than the other groups. Significant differences between the high and low self-reflectivity groups emerged within the first month of placement, while differences between the high and medium groups emerged just prior to the third month. Accounting statistically for a neuropsychological factor known to be related to metacognition and work performance, and for prior treatment (CBT vs. support services), differences persisted between groups. This supported the authors’ hypothesis that deficits in self-reflectivity were a barrier to effective work function. Contrary to expectations, the low and medium self-reflectivity groups were found to have generally comparable levels of work performance.

### Methodological Issues

Notwithstanding the results detailed above, studies suffered from a number of methodological limitations, with an impact on generalisability of findings. Methodological issues will now be discussed and related to the studies in question.

### *Sampling Issues and Generalisability*

Participants included in this review were predominantly male, all had diagnoses of schizophrenia spectrum disorders, and all were involved with psychiatric services. Mean age ranged from 39.59 to 49.63 years, with a median of 47.62 years. Studies of psychosis generally report a mean age of first onset in an individual’s mid-twenties (e.g. Robinson *et al.*, 1999). Therefore, this sample reflected an overall picture of more chronic or enduring difficulties, further supported by the fact that all participants had established diagnoses. As such, this group may not be representative of the overall group of individuals who experience psychosis, restricting the generalisability of results. Studies including females with psychosis, individuals with less chronic or enduring difficulties, individuals representing different age groups (e.g. younger individuals in an earlier stage of psychosis), and individuals not involved in treatment

would be valuable. It is positive to note that Lysaker, Carcione *et al.* (2005), Lysaker, Dimaggio *et al.* (2007), Lysaker, Buck *et al.* (2008), Lysaker, Buck *et al.* (2008), and Lysaker *et al.* (In Press) acknowledged the limited age range of participants and the fact that they were all in treatment as potentially impacting upon the generalisability of results.

### *Recruitment and Retention*

All the studies included in the review used convenience sampling, recruiting from hospital inpatient wards and outpatient or community clinics. None reported on specific recruitment strategies, i.e. advertising, clinician referral, etc. Convenience sampling may introduce selection or sampling biases, thereby impacting upon the external validity of findings. None of the studies reported attrition rates or any impact of attrition on analysis.

### *Exclusion and Inclusion Criteria*

None of the studies by Lysaker and colleagues gave information on inclusion criteria for their samples, although exclusion criteria were provided. It was not always clear whether exclusion criteria were listed exhaustively, e.g. Lysaker, Warman *et al.* (2008) reported that exclusion criteria ‘included mental retardation or active substance abuse’ (p.386). Bosco *et al.* (2009) gave information on both inclusion and exclusion criteria. Clear indication of inclusion and exclusion criteria is critical for replication of studies, and also allows for comparisons between studies and assessment of the generalisability of findings.

### *Covariate Assessment*

Within the samples studied, a number of variables may have impacted upon participants’ discourse and/or metacognition, otherwise accounting for findings. It is outwith the scope of this paper to provide exhaustive consideration of potential covariates. However, key covariates include medication and history of psychological treatments. Whilst it may be challenging to control for all potential confounding variables, careful consideration of the way in which confounders may have impacted upon results can be valuable both in terms of estimating generalisability and guiding future research.

There is evidence that antipsychotic medications impact upon neuropsychological performance and clinical presentation, including factors that may influence communication. Differences have been noted in the effects of different medications and medication groups, e.g. ‘typical’



versus ‘atypical’ antipsychotics (Geddes, Freemantle, Harrison & Bebbington, 2000). Of all included studies, only Bosco *et al.* (2009) reported the type of antipsychotics (typical or atypical) being taken by participants. No papers addressed the issue of medication dosage. In order to control for medication, authors might have calculated Chlorpromazine equivalencies and used this as a covariate in analysis.

History of psychological treatment may also be relevant, as certain treatments may enhance metacognitive performance or ability to engage in discourse. Lysaker *et al.* (In Press) used a sample of individuals who had previously received either cognitive behavioural therapy (CBT) or support services as part of another study. It was a strength of the study that therapeutic assignment was subsequently used as a covariate to ensure that it did not confound results.

### *Control Groups*

The majority of studies did not use a control group. Only Bosco *et al.* (2009) included a control group of ‘healthy persons’, who were matched for sex, age and years of formal education. Inclusion of this control group allowed the group to investigate differences in theory of mind between individuals with and without diagnoses of schizophrenia. Controlling for possible co-variation minimises the chances of data being confounded, and thus represents a relative strength of this study.

### *Power and Analysis*

None of the studies in the review reported whether or not a power calculation had been carried out to determine the sample size required to achieve sufficient statistical power. Several of the studies (Lysaker, Carcione *et al.*, 2005; Lysaker, Buck *et al.*, 2008; and Lysaker, Warman *et al.*, 2008) acknowledged the high number of comparisons being made, and the increased likelihood of spurious findings. Attempts to minimise the risk of spurious findings, e.g. by using more conservative two-tailed tests, were reported by all three of these studies; however, they acknowledged that type I errors remained a possibility. Lysaker, Carcione *et al.* (2005) and Lysaker *et al.* (In Press) reported non-significant trends in their data, which may indicate insufficient power and possible type II errors.

### *Missing Data*

Lysaker *et al.* (In Press) collected data from participants at thirteen different time points. They dealt with missing data by interpolating between observation points, or carrying forward the last observation point ‘when necessary’. This procedure was followed when data was available for at least nine of thirteen possible observation points. However, the authors did not provide details regarding how frequently they required to do this.

### *Inter-Rater Reliability*

All papers included in the review used two ‘blind’ raters to assess inter-rater reliability. Raters in the five studies by Lysaker and colleagues rated between 10 and 25 transcripts, yielding intraclass correlations for the total score of between 0.85 ( $p < 0.05$ ) and 0.93 ( $p < 0.0001$ ) and for all four sub-scales ranging from 0.61 ( $p < 0.05$ ) to 0.89 ( $p$  value not reported). Lysaker, Carcione *et al.* (2005) did not report  $p$  values for inter-rater reliability. However, the analyses suggested satisfactory reliability between raters, and a significant level of internal consistency across all four sub-scales. Raters in the Bosco *et al.* (2009) study rated all transcripts, achieving significant inter-rater reliability on total Th.o.m.a.s. scores (ranging from 0.83 to 0.86,  $p < 0.001$ ) and sub-scale scores (ranging from 0.81 to 0.91,  $p < 0.001$ ).

### *Establishing Causality*

As acknowledged by Lysaker and colleagues, the correlational and quasi-experimental nature of their studies precluded conclusions about the directionality of relationships, and therefore causality. In spite of this, their interpretations of the data often implied directional relationships.

## **Discussion**

This paper aimed to explore measures and methods used to code metacognition in the discourse of individuals who had experienced psychosis, to collate and discuss key findings and to consider the quality of the research underpinning them.

### *Coding Metacognition in Discourse*

Two main means of coding metacognition in discourse were identified in the review: a combination of the IPII and MAS (Lysaker *et al.*, 2002, Lysaker, Carcione *et al.*, 2005;

Semerari *et al.*, 2003) and the Th.o.m.a.s. (Bosco *et al.*, 2009). Both used semi-structured interviews to obtain participant narratives about self and experiences of psychosis, and used structured coding systems to score the extent to which various metacognitive capacities were demonstrated. A relative strength of the MAS is that it can be applied both to psychotherapeutic transcripts and an ‘illness interview’, perhaps offering greater flexibility for clinical and research use than the Th.o.m.a.s.

In spite of using different terminologies, there was overlap between the constructs measured by the MAS and Th.o.m.a.s. Only the Bosco *et al.* (2009) study used more than one means to explore metacognition. It is possible that different results may be yielded by measures of metacognition with greater or lesser elicitation of metacognitive faculties, using different sources of information (to narratives), or in different social contexts.

### *Main Findings regarding Metacognition and Psychosis*

A synthesis of key findings suggested that individuals with schizophrenia spectrum disorders experience compromised metacognitive functioning. In conjunction with the literature, this supports the contention that metacognitive impairments may constitute a core feature of psychotic disorders (Bell *et al.*, 2010). It was also observed that, within this group, different sub-functions of metacognition may be more or less impaired. Results suggested that individuals with predominantly negative symptoms of psychosis may experience greater metacognitive impairments than those with predominantly positive symptoms or general psychopathology. However, better preserved awareness of one’s own mind and the ability to see the world in a decentred manner were associated with greater emotional discomfort. Multiple associations were found between domains of metacognition and neurocognition. Better preserved metacognition appeared to be associated with higher IQ, and fewer or less severe neurocognitive impairments, particularly regarding executive functioning. One domain of metacognition in particular, self-reflectivity, was associated with numerous neuropsychological abilities. Better preserved metacognitive faculties were associated with greater understanding of emotions in others, and higher levels of psychosocial functioning. Impaired metacognition was associated with participants showing less insight, or awareness of their psychiatric conditions. Results also indicated significant associations between greater self-experience, better metacognitive capacity, and lower internalised stigma, i.e. participants with impaired capacity to think about and reflect upon mental states in themselves and others, and who endorsed negative stereotypes of mental illness, constructed more impoverished narratives about experiences of mental illness. Finally, it was demonstrated that individuals with better

metacognitive functioning showed better work performance, making quicker and better-sustained gains in a work environment. This suggests that metacognitive impairments may represent a barrier to effective work functioning, and contributes to a wider body of evidence that impaired metacognition represents a unique obstacle to recovery of function in individuals with schizophrenia spectrum disorders (Brüne, Abdel-Hamid, Lehmkämpfer & Sonntag, 2007).

### *Strengths and Limitations of the Literature*

Studies demonstrated a number of methodological strengths and limitations. It was positive to note that authors were cognisant of factors impacting upon the generalisability of their results. Efforts were made to control for potential confounders, and some salient covariates were included in analyses. A relative strength of the Bosco *et al.* (2009) study was the inclusion of a non-psychiatric control group, which allowed for comparisons between groups. Lysaker *et al.* (In Press) detailed efforts to deal with missing data (e.g. interpolating between observation points) and maximise the validity of statistical analyses (e.g. using conservative tests). All studies reported inter-rater reliability for measures of metacognition in discourse, and these were all satisfactory.

In terms of limitations, convenience sampling yielded a group of participants who may not represent fully the overall group of individuals with psychosis, thus restricting the generalisability of results and demanding replication with more diverse individuals. Reporting of methodologies and analysis could have been more thorough, e.g. regarding attrition rates, and clear, e.g. regarding exclusion criteria. While authors did address some covariates, other relevant covariates were not addressed, e.g. medication. Although it was acknowledged by the authors, Lysaker, Carcione *et al.* (2005), Lysaker, Buck *et al.* (2008), and Lysaker, Warman *et al.* (2008) carried out a high number of comparisons, thereby increasing the risk of spurious findings. Reporting of non-significant trends may indicate that studies were underpowered.

A key limitation of the studies reviewed here was that, while associations were identified between metacognition and various other factors, conclusions could not be made about causality. While the authors often interpreted data in a way that implied directional relationships, e.g. suggesting that neurocognitive impairments may inhibit development of metacognitive faculties, it remains possible that relationships were conversely directional, or indeed that a more dynamic interplay exists between the domains described herein.

### *Clinical Implications*

Results have important implications for clinical practice with individuals who have experienced psychosis. The finding that metacognition is impaired in such individuals identifies a need for the development of interventions that enhance these faculties. As discussed previously, therapeutic approaches have been developed with this objective in mind, such as Metacognitive Interpersonal Therapy (MIT: Dimaggio & Semerari, 2003; Dimaggio *et al.*, 2007) and Bateman and Fonagy's (2004) 'mentalisation-based treatment', with positive results. The results detailed above suggest that restoration or development of metacognitive skills may promote psychosocial functioning, enhancing relationships and vocational performance in other spheres. As such, therapeutic work focused on enhancing metacognition may be understood as recovery-congruent and therefore attractive both in individual and societal terms.

The fact that different domains of metacognition may be more or less impaired than others suggests that there may be value in clinicians assessing metacognitive profiles, such that findings could contribute to formulation and highlight specific areas of need. Associations between metacognition and neurocognition in schizophrenia spectrum disorders, while complex and still only partially explored, may be relevant in helping clinicians to consider likely obstacles to engagement and intervention with such individuals, and to adapt approaches accordingly. Similarly, associations between metacognition and symptom profile may be useful in thinking about appropriate interventions for different individuals. For example, individuals with lesser impaired metacognition may, in fact, experience greater emotional discomfort, requiring psychological interventions aimed at reducing distress as opposed to those indicated by negative symptom profiles, e.g. behavioural activation techniques.

### *Limitations of the Current Review*

The current review was limited by the search parameters previously mentioned, e.g. only papers in the English language were included, and only published manuscripts, leaving the review susceptible to publication bias, i.e. relevant evidence may have been excluded and significant findings overlooked. Only a small number of studies have attempted to code metacognition in the discourse of individuals with psychosis, and of these, a majority have been carried out by one research group (Lysaker and colleagues). Metacognition has 'conceptual cousins' such as empathy, insight and imagination (c.f. Allen, 2006; Choi-Kain & Gunderson, 2007). Due to the variance in definitions of metacognition, and the use of a variety of different terms in reporting on sub-functions, many relevant studies may have been overlooked. For example, studies

exploring insight in the discourse of individuals with schizophrenia spectrum disorders may not have been identified.

The research papers included in this systematic review were rated for methodological quality by only one reviewer. Although methodological critique was discussed with a supervisor, in hindsight it may have been preferable to enhance the rigour of critique by using two raters and employing an instrument by which to rate methodology. However, a suitable instrument was not available, as most existing measures are designed for rating the quality of randomised controlled trials. Given that an instrument developed specifically for this review would be subject to questionable validity and reliability, a discursive approach was felt to be most appropriate, covering areas of methodological quality identified by the Scottish Intercollegiate Guidelines Network guidelines for assessing the quality of cohort studies (SIGN, 2004), the Clinical Trial Assessment Measure (CTAM; Tarrier & Wykes, 2004), and the Consolidated Standards of Reporting Trials Statement (CONSORT; CONSORT Group, 2010).

## **Conclusions**

This review considered how metacognition has been measured in the discourse of individuals with psychosis. Six articles were included, each demonstrating a number of methodological strengths and weaknesses. Studies identified that two main interview-based measures had been used to explore metacognition in this group. Findings indicated that metacognition is compromised in schizophrenia spectrum disorders, with a variegated pattern of impairment across sub-functions. Associations were noted between metacognition and symptom profile, neurocognition, self-experience, awareness and social cognition, and recovery of function. While causality could not be assumed, these findings have important implications for clinicians working with individuals with psychosis, and identified a variety of avenues for future research.

## *Avenues for Future Research*

In order to establish the findings detailed here in a more robust manner, studies should be replicated with more diverse samples, e.g. females, those in an earlier stage of illness, and those refusing treatment. Given the contention surrounding the validity and reliability of diagnostic categorisation in psychotic conditions, it would be interesting to compare metacognitive performance across different diagnoses. The use of a variety of measures of metacognition might confirm that findings were not an artefact of specific interviews or coding systems, and allow for comparisons of how metacognitive sub-functions manifest themselves, e.g. across

different social contexts. As the studies included in this review all employed cross-sectional designs, it would be interesting to conduct studies with longitudinal assessments of narrative and metacognition.

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\* Denotes studies included in final review.

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**Table 1: Study Characteristics**

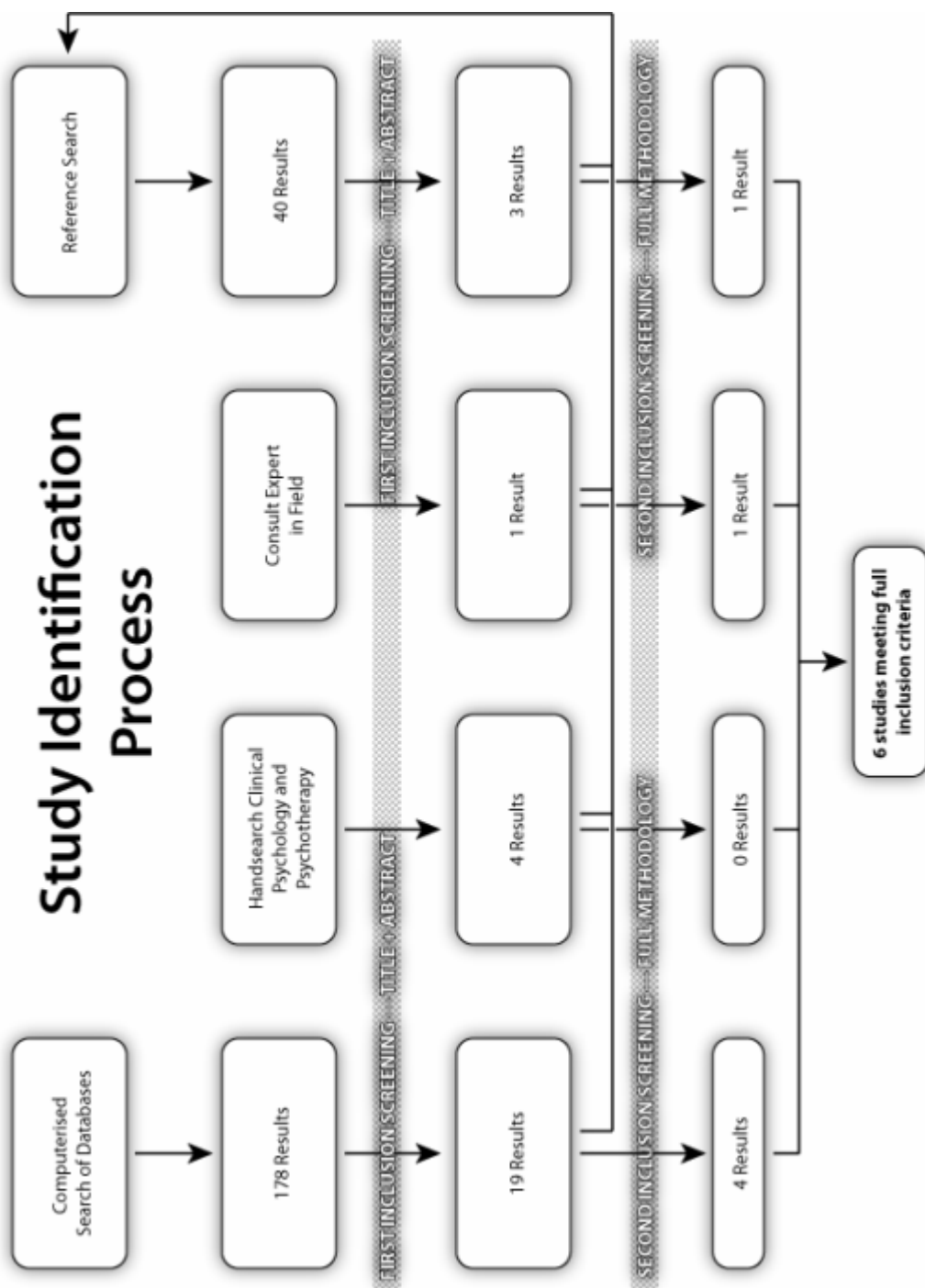
Authors, Year & Sample Characteristics	Interview & Coding Instrument	Relevant Findings	Strengths & Limitations
<p><b>2009</b></p> <p>Bosco, F.M. Colle, L. De Fazio, S. Bono, A. Ruberti, S. Tirassa, M.</p> <p><b>N</b> 22 + 22 controls  <b>Gender</b> 10 male, 12 female  <b>Mean age</b> 39.59 +/- 9.51  <b>Diagnoses</b> Schizophrenia (22)</p>	<p>Theory of Mind Assessment Scale Interview (Th.o.m.a.s.; Bosco <i>et al.</i>, 2009)</p> <p>Theory of Mind Assessment Scale (Th.o.m.a.s.; (Bosco <i>et al.</i>, 2009)</p>	<p>Compared with matched controls, participants with schizophrenia showed impaired ToM across all sub-functions. Participants with schizophrenia showed varied performance across sub-functions. They performed better on 1<sup>st</sup> person than 3<sup>rd</sup> person ToM, and on 1<sup>st</sup> order than 2<sup>nd</sup> order inference.</p> <p>Awareness of mental states was less impaired than understanding of the relationship between mental states and behaviour. Positive and negative symptoms related differently to different sub-functions of ToM.</p>	<p><u>Strengths</u></p> <ul style="list-style-type: none"> <li>• Clear indication of inclusion/exclusion criteria.</li> <li>• Used matched control group.</li> <li>• Use of blind raters to achieve satisfactory inter-rater reliability.</li> </ul> <p><u>Limitations</u></p> <ul style="list-style-type: none"> <li>• Did not control for neurocognitive variables that may have influenced findings.</li> <li>• Did not always provide clear definitions, e.g. 'chronic phase' illness.</li> <li>• Convenience sampling may introduce selection bias.</li> <li>• Did not report specific recruitment strategies.</li> <li>• Did not report attrition rates or impact on analysis.</li> <li>• Did not control for some potentially salient co-variables, e.g. medication.</li> </ul>
<p><b>2005</b></p> <p>Lysaker, P.H. Carcione, A. Dimaggio, G. Johannesen, J.K. Nicolò, G. Procacci, M. Semerari, A.</p> <p><b>N</b> 61  <b>Gender</b> 61 male, 0 female  <b>Mean age</b> 47.7 (SD = 6.8)  <b>Diagnoses</b> Schizophrenia (40)  Schizoaffective Disorder (21)</p>	<p>Indiana Psychiatric Illness Interview (IPII; Lysaker <i>et al.</i>, 2002)</p> <p>MAS (revised version, Lysaker <i>et al.</i>, 2005)</p>	<p>Controlling for age and education, 'understanding one's own mind' was linked with better neurocognition across multiple domains, and less emotional withdrawal. Greater 'understanding of others' minds' was associated with better verbal memory and less emotional withdrawal. Greater metacognition in context of purposeful problem-solving was associated with better verbal memory, insight and social function, and less emotional withdrawal and paranoia.</p>	<p><u>Strengths</u></p> <ul style="list-style-type: none"> <li>• Detailed efforts to minimise risk of spurious findings.</li> <li>• Gave definitions of terms, e.g. 'post-acute' illness.</li> <li>• Acknowledged limited generalisability.</li> <li>• Use of blind raters to achieve satisfactory inter-rater reliability.</li> </ul> <p><u>Limitations</u></p> <ul style="list-style-type: none"> <li>• Generalisability limited by sample composition and fact that narratives procured by one person in one particular social context.</li> <li>• Due to correlational nature of study, no conclusions about causality may be drawn. Discussion sometimes implied directionality.</li> <li>• Multiple correlations increased risk of spurious findings.</li> <li>• Convenience sampling may introduce selection bias.</li> <li>• Did not report specific recruitment strategies.</li> <li>• Did not report attrition rates or impact on analysis.</li> <li>• Exclusion/inclusion criteria not exhaustively listed.</li> <li>• Did not control for some potentially salient co-variables, e.g. medication.</li> </ul>

Authors, Year & Sample Characteristics	Interview & Coding Instrument	Relevant Findings	Strengths & Limitations
<p><b>2007</b></p> <p>Lysaker, P.H. Dimaggio, G. Buck, K.D. Carcione, A. Nicolò, G.</p> <p><b>N</b> 69 <b>Gender</b> 61 male, 8 female <b>Mean age</b> 46.68 (SD = 10.11) <b>Diagnoses</b> Schizophrenia (43) Schizoaffective Disorder (26)</p>	<p>Indiana Psychiatric Illness Interview (IPII; Lysaker <i>et al.</i>, 2002)</p> <p>MAS (revised version, Lysaker <i>et al.</i>, 2005)</p>	<p>Participants lacking basic self-reflectivity had significantly poorer working memory and more symptoms of disorganisation, while participants able to see others as having independent perspectives and relationships demonstrated better visual memory.</p>	<p><u>Strengths</u></p> <ul style="list-style-type: none"> <li>Acknowledged limited generalisability.</li> <li>Use of blind raters to achieve satisfactory inter-rater reliability.</li> </ul> <p><u>Limitations</u></p> <ul style="list-style-type: none"> <li>Generalisability limited by sample composition.</li> <li>Due to correlational nature of study, no conclusions about causality may be drawn. Discussion sometimes implied directionality.</li> <li>Convenience sampling may introduce selection bias.</li> <li>Did not report specific recruitment strategies.</li> <li>Did not report attrition rates or impact on analysis.</li> <li>Exclusion/inclusion criteria not exhaustively listed.</li> <li>Did not control for some potentially salient co-variables, e.g. medication.</li> </ul>
<p><b>2008</b></p> <p>Lysaker, P.H. Buck, K.D. Taylor, A.C. Roe, D.</p> <p><b>N</b> 51 <b>Gender</b> 46 male, 5 female <b>Mean age</b> 48.49 (SD = 9.2) <b>Diagnoses</b> Schizophrenia (31) Schizoaffective Disorder (20)</p>	<p>Indiana Psychiatric Illness Interview (IPII; Lysaker <i>et al.</i>, 2002)</p> <p>MAS (revised version, Lysaker <i>et al.</i>, 2005)</p>	<p>Controlling for age, social desirability and awareness of illness showed that higher STAND ratings (measuring four key aspects of recovery) were significantly associated with greater ratings of metacognitive capacity and lesser ratings of stereotype endorsement.</p>	<p><u>Strengths</u></p> <ul style="list-style-type: none"> <li>Detailed efforts to minimise risk of spurious findings.</li> <li>Acknowledged limited generalisability.</li> <li>Use of blind raters to achieve satisfactory inter-rater reliability.</li> </ul> <p><u>Limitations</u></p> <ul style="list-style-type: none"> <li>Modest sample size and multiple correlations increased risk of spurious findings.</li> <li>Generalisability limited by homogenous sample composition.</li> <li>Convenience sampling may introduce selection bias.</li> <li>Did not report specific recruitment strategies.</li> <li>Did not report attrition rates or impact on analysis.</li> <li>Exclusion/inclusion criteria not exhaustively listed.</li> <li>Did not control for some potentially salient co-variables, e.g. medication.</li> <li>Due to correlational nature of study, no conclusions about causality may be drawn. Discussion sometimes implied directionality.</li> </ul>

Authors, Year & Sample Characteristics	Interview & Coding Instrument	Relevant Findings	Strengths & Limitations
<b>2008</b>  Lysaker, P.H. Warman, D.M. Dimaggio, G. Procacci, M. LaRocco, V.A. Clark, L.K. Dike, C.A. Nicolò, G.  <b>N</b> 49 <b>Gender</b> 49 male, 0 female <b>Mean age</b> 49.63 (SD = 5.71) <b>Diagnoses</b> Schizophrenia (29) Schizoaffective Disorder (20)	Indiana Psychiatric Illness Interview (IPII; Lysaker <i>et al.</i> , 2002)  MAS (revised version, Lysaker <i>et al.</i> , 2005)	Awareness of one's own thoughts and feelings was more closely linked to performance on tests requiring mental flexibility. Recognising others' needs and independent relationships were more closely linked to performance on tasks which required inhibitory control.	<u>Strengths</u> <ul style="list-style-type: none"> <li>Detailed efforts to minimise risk of spurious findings.</li> <li>Acknowledged limited generalisability.</li> <li>Use of blind raters to achieve satisfactory inter-rater reliability.</li> </ul> <u>Limitations</u> <ul style="list-style-type: none"> <li>Modest sample size and multiple correlations increased risk of spurious findings.</li> <li>Did not control for some possible confounds including medication, which may affect executive function.</li> <li>Generalisability limited by sample composition.</li> <li>Convenience sampling may introduce selection bias.</li> <li>Did not report specific recruitment strategies.</li> <li>Did not report attrition rates or impact on analysis.</li> <li>Exclusion/inclusion criteria not exhaustively listed.</li> <li>Did not control for some potentially salient co-variables, e.g. medication.</li> <li>Due to correlational nature of study, no conclusions about causality may be drawn. Discussion sometimes implied directionality.</li> </ul>
<b>In Press</b>  Lysaker, P.H. Dimaggio, G. Carcione, A. Procacci, M. Buck, K.D. Davis, L.W. Nicolò, G.  <b>N</b> 56 <b>Gender</b> 47 Male, 9 Female <b>Mean age</b> 47.54 (SD = 7.53) <b>Diagnoses</b> Schizophrenia Schizoaffective Disorder	Indiana Psychiatric Illness Interview (IPII; Lysaker <i>et al.</i> , 2002)  MAS (revised version, Lysaker <i>et al.</i> , 2005)	Over time, groups with low, medium and high self-reflectivity all achieved higher ratings of work performance in work placement. The high reflectivity group showed generally better work performance than the other two groups. High self-reflectivity group may have improved faster and sustained gains better than other groups.	<u>Strengths</u> <ul style="list-style-type: none"> <li>Acknowledged limited generalisability.</li> <li>Co-varied for previous therapeutic input.</li> <li>Use of blind raters to achieve satisfactory inter-rater reliability.</li> <li>Detailed efforts to deal with missing data.</li> </ul> <u>Limitations</u> <ul style="list-style-type: none"> <li>Generalisability limited by sample composition.</li> <li>Convenience sampling may introduce selection bias.</li> <li>Did not report specific recruitment strategies.</li> <li>Did not report attrition rates or impact on analysis.</li> <li>Exclusion/inclusion criteria not exhaustively listed.</li> <li>Did not control for some potentially salient co-variables, e.g. medication.</li> <li>Did not state how often interpolation or carrying forward was required due to missing data.</li> <li>Due to correlational nature of study, no conclusions about causality may be drawn. Discussion sometimes implied directionality.</li> </ul>



Figure 1: Study Identification Process



## CHAPTER 2

### MAJOR RESEARCH PROJECT

#### **Telling stories: Personal narrative as a construction of recovery processes following psychosis**

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*Prepared according to submission guidelines for Clinical Psychology and Psychotherapy (Appendix 2.1)*

## Abstract

**Background:** Traditional accounts of recovery from psychosis have failed to consider the individual's subjective experience. It has been suggested that individuals may vary in 'recovery style': a predominant manner of reacting to experiences. Personal narratives provide an insight into how individuals process and assign meaning to their experiences, and thus reflect key processes underpinning recovery. **Aims:** The present study aimed to obtain personal narratives relating to recovery from psychosis, and, based on these narratives, to develop a more nuanced and holistic understanding of recovery. **Method:** A sample of nine individuals who had experienced psychosis participated. After providing informed consent, participants were interviewed using an in-depth semi-structured interview. All interviews were transcribed verbatim, with personal identifiers removed to preserve confidentiality. Narratives were analysed using Social-Constructionist Grounded Theory and Narrative Analysis approaches. **Results:** A core process of storytelling emerged, by and through which participants 'charted the landscape of psychosis' within narratives. Themes included 'resounding echoes', 'attempts to reconcile multiple stories and perspectives', 'contextualising psychosis', 'describing the impact of psychosis' and 'managing the impact of psychosis'. Across all themes, participants' stories were influenced by self-perceptions, relationships and experiences, and these in turn were influenced by the storytelling process. Four genres of narrative were discerned: narratives of escape, entrapment, endurance/acceptance, and exploration/discovery. **Applications:** This study offers an insight in to processes of recovery from psychosis, providing a basis for further research into psychotherapeutic processes of recovery from psychosis, and informing the development of psychotherapeutic strategies to support recovery.

## **Key Practitioner Message**

- Individuals' stories about self and experiences of psychosis may represent a vehicle for expression of processes of adaptation and recovery;
- Aspects of clinical presentation, e.g. symptoms, can be viewed as expressions of adaptation, and may offer clues to how an individual is reflecting upon and making sense of experiences;
- Individuals may be assisted in adaptation and recovery by the facilitation of narrative production, and the promotion of reflection and reconciliation of different perspectives;
- The process of storytelling may further contribute to identity construction, social positioning and adaptation to experiences.

## **Keywords**

Psychosis, Recovery, Narrative, Grounded Theory, Narrative Analysis

## **Introduction**

Traditional psychiatric conceptualisations of recovery from psychosis have been criticised for neglecting to consider the individual's *subjective* experience and perspectives (Roberts, 2000). Outcome research has predominantly relied upon quantitative measures of occupational and symptomatic change, but there is evidence that these fail to describe recovery following psychosis fully. Liberman, Kopelowicz, Ventura and Gutkind (2002) demonstrated that clinical symptoms may not improve in parallel with social and functional aspects of recovery. Consultations with mental health service users about the recovery process (e.g. Scottish Recovery Network, 2007) have identified subjective recovery-congruent factors such as the development of positive self-regard and hope for the future, and having meaningful activity and purpose in life. Thus, the outcomes valued by service users may not be described by occupational or symptomatic outcomes alone.

One crucial aspect of recovery from psychosis can be thought of as how the individual responds to and copes with psychotic experiences, the consequences of these experiences (e.g. distress, confusion) and the reactions of others (family, friends and psychiatric services). Also of interest is the way in which these responses themselves shape experiences dynamically. It has been noted that, just as there is variance in clinical outcomes following psychosis, so individuals respond differentially to psychotic experiences. These responses have been conceptualised by

some as an analogue of the individual's wider 'recovery style' – hypothesised to be an enduring and static set of psychological and behavioural reactions to significant events. McGlashan, Levy and Carpenter (1975) distinguished two categories of recovery style, 'integrative' and 'sealing-over', reflected in the narratives of those recovering from psychosis. They proposed that an 'integrative' recovery style is characterised by interest in understanding one's own experiences, with the function of integrating them into one's life story and understanding of self, world and others. In contrast to this, a 'sealing-over' recovery style has been hypothesised to serve a function of dismissing or barring experiences from consciousness, and is manifest in refusal or inability to reflect upon experiences.

There is evidence that recovery style may predict functional and clinical outcomes, and that assessment of recovery style may usefully inform treatment planning (McGlashan, 1987; Thompson, McGorry & Harrigan, 2003). However, in contrast with McGlashan's conceptualisation of recovery style as a stable trait, some researchers have proposed that recovery style may be dynamic. Tait, Birchwood and Trower (2003) carried out a six-month follow-up following acute psychosis in individuals with schizophrenia, and noted adaptability in predominant responses, with apparent shifts between sealing over and integrative recovery styles as reflected by self report questionnaire. Thompson *et al.* (2003) investigated twelve-month outcomes following first episode psychosis and found that recovery style was '*a useful predictor of outcome*' and had the potential to change over time. On the basis of this finding, they suggested that psychological interventions were required to influence recovery style and, in turn, long-term outcomes.

Recovery style may be analogous to an interpersonal stance or response style, rooted in early attachment experiences. In one study of individuals recovering from psychosis, those identified as having a 'sealing-over' recovery style were rated by their mental health key workers as demonstrating lower levels of help-seeking, treatment adherence, and collaboration with services than those with 'integrative' or mixed recovery styles. Such individuals described themselves as having lower self-esteem, greater sensitivity to criticism and rejection in relationships, and having had less caring and more controlling early parental relationships (Tait *et al.*, 2003). Main, Goldwyn and Hesse (2002) proposed the existence of autonomous and non-autonomous states of adult attachment, arising in the context of early developmental experiences. These attachment states are reflected in the structure and coherence of narratives observed in the Adult Attachment Interview (George, Kaplan & Main, 1996). The freely autonomous and secure adult is described as 'free to evaluate' material or experiences related to attachment. Narratives appear independent and objective and are characterised by a valuing of

attachment relationships. The speaker seems able to examine issues from new perspectives, even during discussion of difficult attachment-related experiences including loss, trauma, separation and illness. In contrast, non-autonomous, insecure narratives are either preoccupied (excessive, confused and subjective preoccupation with attachment relationships, often angry or conflicted) or dismissive (where the speaker limits, avoids, or downplays the importance of attachment relationships). In a sample of adults with serious psychiatric disorders, Dozier (1990) found that non-autonomous attachment states predominated, with a strong tendency towards dismissing states of mind amongst individuals with schizophrenia. There is remarkable similarity between descriptions of the 'integrative' recovery style and descriptions of freely autonomous/secure narratives which is mirrored by a similarity between 'sealing over' recovery style and dismissing/ insecure attachment states of mind. This suggests that narratives of recovery from psychosis may be significant not just in terms of the nature and content of experiences that unfold, but also in terms of how narratives may reflect key processes of interpersonal and affective recovery and adaptation.

In recent years, researchers have become increasingly interested in personal narratives: the unique stories constructed by individuals to describe and explain life experiences (Morgan, 2000). It is proposed that narrative production is used to process and assign meaning to experiences. This is in keeping with social-constructionist theories, which identify language and meaning-making processes as vital in the creation of personal and social identities. An individual's life is conceptualised as multi-storied, with the potential to create alternative narratives around a single event. It has been proposed that experiences are organised hierarchically, and that events that fit a dominant plot or 'core narrative' are more closely attended to (Ridgway, 2001). Over time, the core narrative gains richness and supersedes other events, which may be overlooked or forgotten. In particular, Roberts (1999) has emphasised the importance of finding meaning in suffering. Given the proposed importance of narrative processes in making sense of experience, personal narratives may provide an insight into processes of recovery and adaptation following psychosis. Lysaker comments, *'if one's story about self and disorder is an organising force behind how people think and converse about their lives, elicit support and evolve a realistic sense of what can and cannot be done, narrative may be conceptualised as an outcome in itself'* (Lysaker, Davis *et al.*, 2005, p.407). Ridgway (2001) used qualitative methods to analyse first person accounts of recovery following 'prolonged psychiatric disability'. She noted a common shift - instigated by recovery processes - from a core narrative of feeling *'stuck in chronic disability'* towards *'a much more complex and dynamic life story that can best be understood using the metaphor of an ongoing journey'* (p.337).

It has been widely observed that personal narratives of individuals diagnosed with schizophrenia are more likely to demonstrate characteristics such as low levels of agency, coherence and sense of the self as existing in a social world. Lysaker, Wickett, Campbell and Buck (2003) describe schizophrenia as being associated with '*a profound diminishment in the ability to narrate one's life*' (p.538). The characteristics of narratives produced by individuals diagnosed with schizophrenia have been variously defined and conceptualised in the literature. A key question has been the directionality of the relationship between the described narrative characteristics and symptoms of psychosis.

Lysaker and colleagues (Lysaker, Wickett *et al.*, 2005; Lysaker & Buck, 2007) refer to 'deficits' in the narratives/narrative processes of individuals with a diagnosis of schizophrenia, such narratives being comparatively sparse and lacking agency. They propose that these features may be underpinned by metacognitive impairments, such as problems in 'reflexivity' and theory of mind. Reflexivity may be defined as '*subjective awareness and explicit articulation of private mental experience*' (Dilks, Tasker & Wren, 2008). Impairments in reflexivity have been associated with greater difficulty following psychotic experiences, such as deficits in working memory, greater likelihood of negative symptoms and thought disorder, poorer social functioning, greater suspiciousness and more hallucinations (Lysaker, Wickett *et al.*, 2005; Lysaker & Buck, 2007).

Attachment models also provide an explanation for the features of narratives constructed by individuals diagnosed with schizophrenia. According to these models, the ability to talk cogently and coherently about oneself and one's difficult experiences is rooted in the individual's attachment security. For example, Fonagy, Gergely, Jurist and Target (2002) proposed that the construction of coherent personal narratives was dependent upon the individual's capacity for 'mentalisation': recognition that experiences evoke beliefs and emotions in oneself and others, and that certain beliefs and emotions are likely to result in corresponding behaviours. This is a developmental capacity, achieved optimally in the context of secure early attachment relationships, in which a contingency is constructed between experiences of distress and relief of distress via the consistent interventions of attuned caregivers (Meins *et al.*, 1998). Mentalisation allows the individual to reflect upon the mental states of him- or herself and others, and to utilise this knowledge to solve problems, negotiate transitions or adapt to stressful life events. It is demonstrated, in adulthood, by the production of coherent personal narratives. Gumley, Schwannauer, Macbeth and Read (2008) supported the argument that narrative coherence can be understood as an outcome of attachment-related

experience. They proposed that coherence, in turn, reflects an individual's capacity for cognitive and emotional regulation, especially in the face of distressing events involving threat, trauma, separation and loss (Bowlby, 1969, 1973, 1980). Similarly, Holmes (2001) suggested that the ability to construct coherent and collaborative narratives is a feature of psychological resilience, or a 'psychological immune system' that provides protection against future trauma and adversity.

Given that there are a number of relevant pre-existing perspectives on recovery narrative after psychosis, emphasising attachment (Gumley *et al.*, 2008), metacognition (Lysaker, Davis *et al.*, 2005; Lysaker & Buck, 2007) and recovery style (McGlashan *et al.*, 1975), the point of departure for the current study was to explore narratives of individuals reflecting upon their experiences of psychosis and recovery. It was hoped that insights provided would inform the development of narrative-based approaches to evaluating recovery and adaptation following psychosis. The study therefore aimed further to develop theories of recovery and adaptation following psychosis by obtaining narratives of individuals' perspectives and experiences of psychosis and recovery using an in-depth semi-structured interview and exploring the content and structure of these narratives using Grounded Theory and Narrative Analysis methodologies.

## **Methods**

### Participants

Nine individuals participated in the study. Participants were recruited via advertisement at two mental health services in NHS Greater Glasgow and Clyde. Two participants were recruited from a community-based service for individuals aged 16-35 with a first episode of psychosis, and seven participants were recruited from a psychiatric inpatient unit. All participants had experienced affective or non-affective psychosis, as diagnosed by the psychiatrist responsible for their care, and verified by examination of case notes. There were 5 male and 4 female participants, ranging from 25 to 67 years old, with a median age of 31. Participant characteristics and pseudonyms are provided in Table 1. All participants consented voluntarily to participation in the study.

INSERT TABLE 1 ABOUT HERE

Due to the qualitative nature of the study, it was not possible to perform a power calculation to determine sample size. Turpin *et al.* (1997) suggested that a sample of 8-20 participants is



desirable for qualitative research conducted as part of a Doctorate in Clinical Psychology. In this study, recruitment was concluded at the point that no new themes or theories were emerging from the data.

### Procedure

Ethical approval for this project was granted by the NHS Greater Glasgow and Clyde Research Ethics Committee (reference: 08-S0701-173; Appendix 2.2) and management approval came from NHS Greater Glasgow and Clyde Research and Development directorate (reference: PN08CP536; Appendix 2.3).

Initially, meetings were arranged between the researcher and staff groups at the recruitment sites. At these meetings, the researcher provided staff with information about the study and its aims. Following this, advertisements (Appendix 2.4) and information sheets (Appendix 2.5) were placed in reception areas of inpatient wards, and sent to all service users at the community-based service who would be eligible for participation (the community-based service has no reception areas). The advertisement included a brief description of the study, with a tear-off slip and stamped, addressed envelope for individuals interested in participation. Detailed information sheets were attached to the advertisements. Individuals were invited, on a voluntary basis, to contact the researcher if interested in participation, by completing and returning the tear-off slip.

Individuals returning the tear-off slip were contacted by the researcher. They were given the opportunity to ask questions about the study. The eleven people who expressed interest in participation were asked to consent to the researcher contacting their key worker and psychiatrist to establish eligibility for participation, and ensure that involvement was unlikely to impede any ongoing treatment. When this was ascertained, individuals were invited to an initial meeting at the base of the mental health service with which they were involved. This ensured that individuals had time to consider the information and make an informed decision. At the initial meeting, consent to participate was sought, using a plain language consent form (Appendix 2.6). This clearly delineated potential risks of participation, and emphasised participants' right to withdraw from the study at any time. Of eleven potential participants, two individuals (both at the psychiatric inpatient unit) chose not to participate at this stage. For the nine individuals who consented to participate, an interview was arranged.

## Interview Development

Prior to data collection, a semi-structured interview was developed, with input from two clinical psychologists with clinical and research experience of psychosis (Appendix 2.7). The interview aimed to stimulate narrative around experiences of psychosis and recovery. Through a process of group discussion and re-drafting, a written schedule was developed to guide the interviewer. Flexibility was incorporated, allowing participants to ‘shape’ the interview through engagement, reflectiveness, and choice of topic. Participants were initially asked broad, open-ended questions about their experiences of psychosis. This was intended to facilitate dialogue, allowing discussion and spontaneous reflection upon experiences. According to participants’ responses, the interviewer gave prompts, with an increasing demand for reflexivity and narrative production (a ‘funnel structure’). The interview was structured around a framework of six core ‘open’ questions, with ‘demand’ prompts (e.g. ‘What did you think about that?’ or ‘How did you feel at the time?’) where a participant did not reflect spontaneously. The interviewer adopted an open, curious and non-judgemental attitude. Active, empathic listening was used to allow participants to provide open and free-flowing narratives. The use of medical terminology and jargon was avoided, such that participants could employ personal language and perspectives. Clinical techniques, such as summarising and reflecting back, were used to confirm understanding, clarify stances and facilitate dialogue. An effort was made by the interviewer to avoid introducing new material to the emerging narrative.

## Interviews

Interviews were conducted by the chief investigator (BA). Each participant was interviewed once, using a semi-structured interview. Interviews took place at the premises of the mental health service with which each individual was involved. Length of interview was flexible and responsive to each individual’s level of engagement, reflexivity, etc. Due to technical failure, two interviews were not recorded in full; however, there were sufficient data for meaningful analysis. Recordings ranged in length from 27 minutes 24 seconds (an incomplete recording) to 71 minutes 6 seconds, with a median length of 47 minutes 24 seconds.

Each site at which interviews took place was assessed separately in terms of health and safety issues, and arrangements were overseen by local field supervisors. Health and safety arrangements were agreed with the management of each mental health service prior to commencement of research. During interview sessions, at least one other mental health professional was on the premises at all times. Participants were made aware of the opportunity

to access support from a mental health professional following sessions with the chief investigator. No participant chose to accept this offer.

Immediately following interview sessions and throughout the process of data analysis, the chief investigator made notes ('memos'). These included thoughts and feelings engendered by the interview, areas of interest or insight, and emergent ideas or theories. The purpose of memos was to enhance recall and facilitate ongoing reflection. The chief investigator transcribed interviews verbatim as soon as possible, following guidelines for transcribing the Adult Attachment Interview (George *et al.*, 1996). Insights or areas of interest identified in memos were addressed in subsequent interviews. In this way, analysis of data shaped the ongoing data collection process, ensuring fidelity to the Grounded Theory model (Charmaz, 2006).

Research supervision with a qualified clinical psychologist occurred on a regular basis, with time dedicated to talking about interviews, transcription and coding. This gave the chief investigator an opportunity to reflect on her experience of interviewing, to articulate and discuss thoughts and theories about the data, and to benefit from the insights of another clinical psychologist, who had experience of working clinically and as a researcher with individuals with psychosis using qualitative methodologies.

## Analysis

### *Grounded Theory*

Initial analysis of data was conducted using Grounded Theory methods. These methods aim to allow theories to emerge from the data (Charmaz, 2006). Theories generated in this way are 'grounded' in the data, but are interpretive and flexible, rather than absolute (Bryant, 2002; Charmaz, 1995). A social-constructionist update to Glaser and Strauss's original (1967) Grounded Theory emphasises the interactive process of constructing knowledge and understanding in dialogue (Charmaz, 2003). It posits that data and analysis are mediated by researcher-participant relationships and the shared interview experience.

Transcripts were initially subject to line-by-line coding, with codes closely following the language and content of raw data. This enabled the researcher to become familiar with the data and to notice codes that arose frequently or seemed significant, and emerging relationships between codes. Throughout this stage, the researcher kept detailed memos of frequent and significant codes. Importantly, care was taken to avoid imposing pre-conceived hypotheses or

theories upon the data. Subsequently, a second phase of focused qualitative analysis integrated and synthesised codes to produce preliminary higher-order 'categories', or overall themes that helped to make sense of the data. Advanced memos allowed the researcher to record potential categorical connections within and between interviews. These connections were characterised in the final stage of theoretical coding.

Charmaz (2006) describes the constant comparative approach as being central to Grounded Theory. In this study, codes arising from each interview were compared with other codes in the same interview, and also with codes arising from other interviews, to allow appreciation of similarities and differences. This continued through the stages of line-by-line coding, focused coding and theoretical coding, facilitating the emergence of theories from data. Theories were later compared 'backwards' to the data set.

### *Narrative Genre*

It has been proposed that clinically relevant research is improved by ongoing formulation, clarification and refinement of research questions (Barker, Pistrang & Elliott, 2002). Harper (2007) delineates a variety of qualitative clinical research methods, their differing epistemologies, and the kinds of research question they have previously been used to address. While Grounded Theory is noted to be '*well-suited to developing theoretical models from unstructured data*', Narrative Analysis is described as focusing upon individuals' stories and how they change over time (p.436). Harper cautions researchers to consider carefully the most appropriate method, according to the research question and aims.

In this study, a core theme of storytelling emerged during Grounded Theory analysis, which will be discussed in detail in the results section. Although not fully anticipated, this finding inspired a further iteration of analysis, asking of the data what *kinds* of story were being told. Thus, a second phase of analysis was added retrospectively, in which the aim was to characterise narratives according to genre. With this intention, narrative research - particularly that exploring 'illness narratives' - has often used 'holistic-form' analysis (Lieblich, Tuval-Mashiach & Zilber, 1998). This study was informed in particular by Thornhill, Clare and May's (2004) research, which was similarly interested in the kinds of story emerging in participant narratives, and focused upon features such as plot development, structure and use of language. Re-examining each transcript in this way allowed four distinctive categories of story to emerge, each with a dominant characterisation of the main protagonist. These genres and characterisations were named using concepts and language grounded in the narratives

themselves. Grounded Theory and Narrative Analysis methods can be understood as complementary, sharing social-constructionist epistemologies. In this study, the secondary phase of analysis was, itself, grounded in the data, emerging out of the first, Grounded Theory, phase of analysis.

Narrative analysis involved reading and re-reading each transcript, and interrogating the data according to its *genre*: the holistic form of the narrative and the dominant self-characterisation of the narrator. The approach was informed by Thornhill, Clare and May's (2004) study, in which the key question asked of transcripts was 'What kind of a story is this?' In the current study, a further question was also considered: 'What kind of a story-teller is this?' Aspects such as plot development, structure and language use contributed to how these questions were answered. Each transcript was explored in this manner, allowing different types of story and story-teller to emerge. These were then categorised according to recognised genres and characterisations, which were named according to language or concepts arising from the data itself. Within each transcript, it was often possible to discern more than one narrative and self-characterisation. Therefore, the researcher's subjective response to the narrative makes a key contribution to the analysis, alongside the participant's storytelling. In the process of analysis, different emerging stories and self-characterisations were noted and discussed by the chief investigator and research supervisor. For the purposes of this study, genre and self-characterisation were restricted to the overall, or dominant, holistic form and self-characterisation of each narrative.

### *Review of Analysis*

Grounded Theory was thought to offer considerable advantages to this study, in that the approach is attentive to and can account for the complexity, variability and context of social and psychological phenomena. Conceptualisations and theories that emerge using the approach are grounded in concrete data and phenomena. The validity of interpretations in Grounded Theory is optimised by the use of constant comparative methods, through which emerging conceptualisations are confirmed or challenged, areas identified for further exploration, and new meanings constructed. A particular strength of Grounded Theory is flexibility: theories and conceptualisation are free to evolve in light of new information emerging from data (Wuest, 2000).

The social-constructionist version of Grounded Theory analysis employed in the current study considers narratives as co-constructed in the context of the relationship between participant and

researcher. Efforts were made by the researcher to remain aware of the impact of personal thoughts, feelings and beliefs upon dialogue and interpretation, and to 'ground' descriptions and interpretations in participants' own language, as recommended by Dallos (2006). These measures, as well as regular discussion with a supervisor, allowed conceptualisations and theories to emerge and unfold from the data, with the impact of context being recognised and appreciated, rather than seen as a limitation. Grounded Theory methodologies have been subject to criticisms such as the 'charge of relativism', which queries the value of one researcher's interpretations in comparison with those of others. Strauss and Corbin (1994), however, have disputed the existence of a singular 'reality', calling this 'a positivistic position that...we reject... Our position is that truth is enacted' (p.279). This relativist ontological position negates attempts to discover one 'truth' within data. As such, the findings detailed in this study are not presented as an absolute or universal representation of recovery and adaptation following psychosis. Rather, as embodied in the study's aims, it is hoped that the results will further develop theories of recovery and adaptation following psychosis, not only considered on their own merits, but by enabling future researchers to compare samples, phenomena and contexts.

The qualitative researcher has recourse to a number of potential methodological and analytical approaches, such as Discourse Analysis (DA), Grounded Theory and Interpretative Phenomenological Analysis (IPA). Such approaches, while different, overlap in many aspects of their epistemological, theoretical and methodological underpinnings (Smith, 2004). IPA and Grounded Theory share a focus on exploring how individuals experience and make sense of the world. Each approach acknowledges that both participant and researcher play roles in accessing and understanding participants' experiences, and that the researcher's own beliefs and experiences impact upon the interpretive process. However, IPA places a greater emphasis on cognitive processes, proposing that these are represented by participants' language. Thus, IPA is affected by the ability of participants to use language effectively to communicate their experiences. Willig (2001, p.64) wonders, '*how many people are able to use language in such a way as to capture the subtleties and nuances of their physical and emotional experiences?*' This question is perhaps even more pertinent when the people in question have experienced psychosis. Clinical literature has broadly identified a diminished capacity, in individuals with schizophrenia, to construct autobiographical narratives (Lysaker *et al.*, 2003). Furthermore, the use of IPA is predicated upon the use of small, homogeneous samples. In a study such as this, which considers highly complex and idiosyncratic experiences, it is challenging to achieve homogeneity. In contrast with IPA and Grounded Theory, DA does not specifically address individual experiences, instead emphasising the construction of language, and considering

particularly the cultural and linguistic factors that affect thought, language and action (Georgaca, 2000). DA was therefore not seen as an appropriate methodology for this study.

## Results

Where excerpts of interviews are provided, pseudonyms have been used to protect the identity of participants while preserving each unique identity or character. Comments made by participants are reported in normal type, while comments made by the interviewer are reported in **bold** type. Brief remarks by the person not speaking are denoted within the main dialogue by the use of italics in parentheses, e.g. (*right, okay*). Brief pauses of under three seconds are represented by two hyphens, i.e. --, while longer pauses or editorial comments are presented in braces, with the length of the pause provided, e.g. {{3 seconds}} or {{laughing}}.

The interview was constructed to provide participants with opportunities to describe and reflect upon their experiences of psychosis, while affording them freedom to individualise the stories they told. The funnel structure of the interview encouraged participants to reflect spontaneously upon their experiences, with broad, open questions segueing in to increasingly demanding prompts towards focused reflection. The interview appeared to stimulate narrative successfully, with data providing a rich and nuanced picture of psychosis and recovery. It seemed that the structure provided sufficient flexibility for participants to tell personalised, idiosyncratic narratives, while allowing common processes and themes to emerge across the sample. For the purposes of clarity and succinctness, core processes and themes identified will be presented here in their final form, without in-depth descriptions of early codes and conceptualisations. This report focuses on results relating to experiences of psychosis and recovery, and does not necessarily represent an exhaustive analysis of all data.

A summary of key findings is depicted in Figure 1. This portrays the core process of storytelling, themes consistent within that process (resounding echoes, reconciling multiple stories and perspectives, contextualising, describing the impact of psychosis and managing the impact of psychosis), and factors that shared a dynamic interplay with storytelling (relationships and social positioning, self-perceptions and identity construction, and experiences and adaptation). Different ‘genres’ of story told by participants are also listed (escape, entrapment, endurance and exploration).

INSERT FIGURE 1 ABOUT HERE

### A Core Process of Storytelling

Analysis revealed a universal process of storytelling, with participants appearing ready and willing to engage in developing an account of their experiences. Salient characteristics of stories will be discussed in detail forthwith. The storytelling process was understood as being jointly negotiated between the participant and interviewer, with both parties contributing to the emerging narrative in the course of dialogue. Interviewer and participant assumed complementary roles in the process. The interviewer scaffolded participants' discourse by guiding them through a series of questions, prompting further reflection where this did not occur spontaneously, and using conversational strategies such as summarising and reflecting back. Participants used strategies such as contextualising and clarifying to ensure the interviewer's understanding. In this way, a shared language was established, and narratives of participants' experiences were mutually constructed.

Analysis suggested that the 'core process of storytelling' related to three key areas or activities: identity construction and self-perception, positioning of the self in an interpersonal world, and adapting to life events or experiences. These three areas both emerged *out* of the process of storytelling, and contributed *in* to the way that participants portrayed their stories. As such, there were dynamic, multi-dimensional interactions between these areas, both within and outwith the storytelling process.

### *Resounding Echoes*

The importance of the three key areas outlined above was illustrated in interviews by the way in which 'echoes' of experiences, self-perceptions and relationships appeared to sound and resound throughout stories. Participants' pasts and presents appeared to contribute to the characterisation of each other, with the core process of storytelling providing a vehicle for this.

For the purposes of illustration, consider the following excerpts, in which a participant's past experiences, self-perceptions and relationships appear to influence his adaptation to new experiences, the way in which he constructs his identity, and the way in which he positions himself in the social world. Michael talked about childhood experiences of witnessing '*abuse and... domestic violence*' between his parents, and how this impacted upon him at that time:



Michael: I don't have any brothers and sisters (*okay*) so I was kind of on my own, and it just, it was kind of hard to cope with (*absolutely*) because nobody else kind of really knew what was happening, and kind of, I put on a kind of, eh - - an act, I suppose (*yeah*) around other fam-, family members and stuff, and extended family, and kind of, you were kind of pretending to be happy families when it was just very different, and so it was kind of like bottling up a lot of stuff (*yup*) and trying to deal with it...

Here, Michael refers to his childhood self as being alone, finding it '*hard to cope*' with experiences, nobody knowing what was going on for him, '*pretending*' and putting on an act, but actually '*bottling up a lot of stuff*' and '*trying to deal with it*'. One way in which self-perceptions and the interpersonal world seemed to interface was in the way that individuals '*positioned*' themselves in relation to others. Observe the striking similarities in how Michael now characterises himself and his interactions with others:

Michael: I've always been very good at kind of giving the impression that everything's fine and kind of (*right*), eh, sort of playing the role of someone who's fine (*uh huh*) but underneath the surface I'm kind of, it's a bit different...

As aforementioned, the interplay between past experiences, self-perceptions and relationships is not unidirectional or linear, but multidimensional and dynamic. Thus, the process of storytelling and the emerging story themselves serve to influence the activities of identity construction, social positioning and adaptation. Here, Michael reflects on how he tends to '*deal with things*', and considers alternative perspectives on this aspect of himself:

Michael: ...it's a double-edged sword type of thing, like, ehm, the fact that I do like to kind of, eh, deal with things on my own and be kind of independent and self-reliant, 'cause in a lot of ways, you know, that's a good trait to have, and sort of, you know, helps you get on in certain aspects of your life, but then it can leave you - - like I said, kind of alone (*yeah*) and dealing with everything on my own, and not being able to cope and not being able to share the burden, or not being able to, eh, kind of, eh - - I don't know, like, open up to other people....

### *Reconciling Multiple Stories and Perspectives*

Although narratives could be distinguished by their 'genre' (the dominant plotline) and the characterisation of the storyteller as protagonist, analysis found that they could contain several stories, or stories nested within stories. Participants varied in the extent to which this was apparent: some retained a keen focus on the story of their psychosis, some interwove this with

stories about other experiences, and others presented seemingly unrelated stories. For example, Jeffrey told the story of his psychosis, but also a story about the generations of men in his family, and how their influence had impacted upon him and his recent experiences. Lindsay told the story of her psychosis, but also a story of how she had become a mother and felt burdened by this. She linked this to the onset of her mental health difficulties. Andrew told the story of his psychosis, and nested a story about his hospitalisation within this, using it to illustrate his struggle to discern danger from safety. By contrast, George's narrative contained stories about getting a haircut and about the deterioration in his physical health, which seemed dissociated or disconnected from the wider story of his psychosis. He did not attempt to reconcile these stories by sharing their links with the interviewer.

Of interest, participants sometimes presented multiple perspectives or 'selves' - for example in the way that they characterised themselves, their interactions with others and their experiences - *within* their narratives. Again, participants varied in the extent to which they portrayed singular or multiple perspectives. Some participants' narratives were dominated by a unitary characterisation, with little discrepancy in attributes or stances within the narrative. Others gave more complex, multi-faceted accounts, in which multiple characterisations of the self were depicted within the narrative and across the stories told. The degree to which multiple stories and multiple selves were acknowledged and reconciled or 'integrated' with one another varied across individuals. While conflicting or disparate aspects of stories and portrayals of the self, relationships and experiences were sometimes addressed openly, this was rare. It was more common for participants to present unresolved discrepancies between stories and selves, or struggles to reconcile them. This was particularly striking when contradictory information was presented without acknowledgement. Note the startling variance in Jean's descriptions of her relationship with her mother:

Jean: I wanted to be a [job title] (*ah, okay*), and I'd gone and got all the information. I thought, she's gonna be delighted: I've actually chosen an actual career (*uh huh*). And she just went mental. Absolutely mental (...) I was in a daze for about three hours. And I had to phone the Samaritans, 'cause I felt so bad.

Jean: She's always been supportive. I mean t-, I could murder somebody and she would still support me (*right*). I mean, that, that's how strongly she, she feels about all her children (*uh huh, uh huh*) . . . . {{4 seconds}} As long as we're all happy, she's happy.

Here, Jean presents her mother as going ‘mental’ when Jean told her about a career choice. On the contrary, she also presents her mother as extremely supportive. Such contrasts, rather than being ‘connected up’ by the story, instead seemed dissociated and unresolved from one another: Jean did not comment on the apparent contradictions in her story. This can be contrasted with Jeffrey’s account of his relationship with his father. Like Jean, Jeffrey presents different aspects of the relationship. However, the different perspectives are resolved in the narrative by their interaction with one another. It is as though the stories are somehow ‘knit together’ by and through the storytelling process.

Jeffrey: ...when I graduated, my father took me aside afterwards - - ‘cause, ‘cause there had been no congratulations: nothing like that (*okay*). And my father took me aside and in a conspiratorial whisper, as if it was something... deep, dark secret that he was telling me that must never be repeated, he said, “Of course, you know that your mother and I are very proud of you, but we don’t like to keep telling you in case, in case you get a big head,” (*oh, okay*). Okay?

**Interviewer: And what did you think about that?**

Jeffrey: Um - - I remember thinking, “Well, it wouldn’t hurt. And I wouldn’t get a big head, actually.”

Jeffrey: ...my dad and I didn’t have . . . . {{3 secs}} ...we shook hands, there was, the word love was never mentioned. Um... And when he died on [date] (*mm hmm*), I didn’t know how I felt about it (*mm hmm*) - - and I didn’t know until a few weeks ago (*yeah*) but it, it sort of just dawned on me, it was a, a bit dim, I think, but it dawned on me that of course he loved me, because he, he, he taught me how to garden (...) and he taught me DIY (*uh huh*) and he taught me how to play golf (*right*).

Jeffrey openly acknowledges his mixed feelings, and is able to move in a more fluid way between different perspectives illustrated in his story. He reconciled these perspectives by bridging gaps between them with a story about his father’s experiences and how these impacted upon him, and in turn the father-son relationship. Resolution of conflict left Jeffrey feeling ‘*at ease*’. Conflicts or ‘stretch’ emerged within narratives on a number of levels, including between perspectives on an event or experience, between perceptions of the self (including contrasts between the perceived self and an ‘ideal self’), and between self-positions in relation to others.

## Charting the Landscape of Psychosis

Prior to participation in the study, individuals provided informed consent based on advertisements, detailed information sheets, and further discussion with the chief investigator where desired. Thus, they were aware of the key task of discussing their experience of psychosis. Participants employed a number of strategies to ‘chart the landscape of psychosis’, including providing contextual information, describing the impact of psychosis, and talking about means of coping. Some main features of narratives and narrative construction will now be discussed in depth.

### *Contextualising Psychosis*

Participants were asked to give a summary of experiences that led them to have contact with mental health services, and then to discuss specific times of particular importance in their story. Clear efforts were made to contextualise the experience of psychosis by the portrayal of key events, self-perceptions and interpersonal environments. As aforementioned, these factors appeared to dynamically shape participants’ entry to, journey through, and exit from the experience of psychosis. The ‘weight’ given to each factor varied across participants, with some placing a strong emphasis on the importance of one in particular (e.g. a specific traumatic event) and others presenting a more equivocal account, in which two or all three areas were referred to. Trauma or difficulty in these areas appeared especially salient in contextualising experiences of psychosis, as illustrated below.

Andrew and Gemma presented particularly stressful or traumatic life events, which they identified as relevant to their coming in to contact with mental health services:

**Interviewer: What led you to come in to contact with mental health services?**

Andrew: Ehm, just growing up, and being, like, attacked when I was really young. I got, eh, glassed in the face and stabbed when I was fifteen years old (*right, okay*).

**Interviewer: I’m really interested in... ehm... the experiences that you had that led you to come in to contact with mental health services (*mm hmm*), whatever you see those to be (...)**

Gemma: Right, right. Ehm, well, I was... I’ve been raped twice (*right*). I was raped at [age] and raped at [age] (*okay*) and I had, eh, sexual assaults when I was [age] and [age] (*right*).

Throughout analysis, it was apparent that relationships were a key influence in shaping stories. The data were suffused with material related to interpersonal relationships, and participants repeatedly returned to describing and reflecting upon their social worlds, often unprompted. Relationships were portrayed as a source of support or strain, and sometimes a mixture of both. Support and strain were discussed in instrumental, social and emotional terms. In contextualising the emergence of psychosis, participants appeared more readily able to access negative interpersonal experiences, such as rejection, loss, threat, negative self-other comparisons, conflict, neglect and isolation, than of positive support. For instance, Lindsay and James talked about how relationship difficulties contributed to their mental health problems. Notice the interplay, in Lindsay's narrative, between experiences, relationships and self-perceptions. Lindsay's self-perceptions, for example, influenced the way in which she functioned in her interpersonal environment and adapted to life experiences.

**Interviewer: So I wondered if you could start by giving me an overall summary of those experiences, starting with what led you to come in to contact with [Mental Health Service]...**

James: Basically, eh, I fell out with my partner, so I did (*mm*) and she taken away my kid, and stuff like that. It was maybe, like, four weeks later, you know (*right*), I started hearing these voices, you know?

Lindsay: Oh, he was drunk the whole weekend, and sometimes on the Monday.

**Interviewer: What did you kind of - how did that make you feel?**

Lindsay: A doormat! I told him! "You're just treating me like a doormat!" (*Mm hmm*) Um... just somebody that gets walked over daily (*mm hmm*), you know? (...) Um, and eh... [my husband], he had apologised, and little things to me mean so much, you know? If he brought me in a single flower that he had picked from something (*uh huh*), that means more to me than... you know? So I would accept things like that, you know, I would accept it when he apologised and, you know, and... you know? At some point it would start again...

Supportive relationships or experiences were explored in more detail when participants talked about managing the impact of psychosis. This will be discussed separately forthwith.

Stress and trauma were also present in participants' accounts of their intra-personal worlds. Some referred to perceived self-characteristics, or actions they had taken, that they saw as important in their story of psychosis. In keeping with the theme of stress and trauma, these tended to be presented as undesirable, negative or uncomfortable states, traits or actions. For example, Gemma saw herself as generally '*negative*' and '*guilty*' about experiences, Lindsay described feeling '*so much anger*' about her circumstances, and James referred to the

difficulties with his partner as being '*to do with the way I was treating her*'. The way in which participants described themselves as having a role in the unfolding story of their psychoses is illustrated below:

**Interviewer: ...I wondered if we could start by you giving me a summary of those experiences up to when you came in to contact with mental health services? (...)**

Jean: Just really, eh, I was kind of rebellious. My mum put that down to thinking I was rebellious and not listening to her and things, and I ended up in, staying in hostels, and I ended up taking drugs (*uh huh*) and it all came to a head, and it manifested itself in what I thought at the time, and the doctors thought, was schizophrenia (*uh huh*). That's when I was admitted to [the hospital] down the road (*right*).

**Interviewer: ...I wondered if we could start, if you could tell me a summary (yes) of the experiences that led you to come in to contact with the mental health services.**

Graham: You mean this, this time?

**Interviewer: Or even the first time?**

Graham: Oh, I'd rather not talk about that (*okay*) - too unpleasant. I, I wisnae violent or... I was not very well behaved.

**Interviewer: You weren't very well behaved?**

Graham: No.

While narratives varied in sense of individual agency and richness of detail provided, the strategy of contextualising was implemented by all participants to a greater or lesser extent, and as such appeared to be not just important in helping participants to describe experiences of psychosis, but a fundamental aspect of the storytelling process.

### *Describing the Impact of Psychosis*

Participants in the study described a range of experiences under the 'umbrella' of psychosis, including hearing voices, 'seeing gremlins', visual disturbances, extreme affect, changeable affect, changes in appetite, sleep disturbance, thought disturbance, dissociative experiences, paranoia, panic attacks, and parasuicidality. Symptoms were presented and described in terms of their impact on the individual's life and ordinary functioning. The impact of psychosis appeared to be pervasive, affecting emotions, sense of identity and role, relationships with others, occupational activity, and thoughts and feelings about the world and future. Across these areas, participants discussed experiences of upheaval, change and loss. The affective impact of psychosis varied across and within narratives. Participants used a range of words to

describe experiences, including *'terrifying', 'frightening' 'intense', 'confusing', 'comforting', 'a buzz' and 'exhilarating'*. Similarly, emotions were both negative and positive, with participants describing feeling: *'anxious', 'stressed', 'lonely', 'scared', 'helpless', 'angry', 'not quite safe', 'panicky', 'safe', 'happy' and 'blissful'*. With a whole spectrum of feelings represented within narratives, the predominant sense was of emotional upheaval.

Psychosis had clearly impacted upon participants' interpersonal worlds, both in the way that they perceived others, and how they positioned themselves socially. For some, the emergence of psychosis was associated with loss of relationships, whether due to their own withdrawal, or perceived withdrawal by others. James reported that *'everybody kinda, when I took no well, they all kinda back-seater (uh huh) and I never seen them again (right) for like months on end (uh huh), you know? And it was as if they just kinda gie'd up on me, you know?'* Participants also described psychological losses, such as loss of trust and confidence. A number of participants described a loss of trust in others. Andrew said, *'I don't trust anyone'* and James spoke about how, travelling through psychosis, *'it is hard to trust people.'* Loss of role and identity associated with psychosis was another theme across participants. Some discussed the way in which the experience of psychosis had forced them to step outside their ordinary identities and assume a new role, or had resulted in them losing their sense of autonomy:

Jean: I've never been a needy person, and it was very hard having to be needy when I first became ill. That was a *(right)* massive blow to me *(uh huh)*.

Psychosis also changed participants' everyday lives and routines. A number talked about ways they had been prevented from normal function, from getting enough sleep and feeling able to go about one's business, to engaging in education or employment.

Michael: ...my head was just, ehm, in a terrible mess, basically *(uh huh)*. Um, so - - uhm, yeah, I had to quit the job.

James: ...I could hear something *(yeah)* speaking tae me, but I couldnae hear it, you know? And it was if it was trying tae make me say *(yup)* stupid things, you know? Like I was always watching what I was saying, and I became worried about going out of the house *(right)* and stuff like that.

Descriptions of the impact of psychosis were accompanied by discourse about coping strategies, which will now be discussed.

As aforementioned, participants presented and described symptoms of psychosis according to their impact upon self-perceptions, relationships, and ordinary functioning. Similarly, the way they described managing the impact of psychosis cast light upon how they had adapted to experiences of psychosis and re-calibrated their self-perceptions, social position and functioning to cope with the experience, integrate new knowledge and perspectives, and establish or re-establish movement and growth. This adaptation was often mirrored in the way that participants told their stories, e.g. an individual who described trying to avoid uncomfortable thoughts might also demonstrate a reluctance to reflect upon challenging experiences in discourse.

Throughout interviews, participants talked directly and indirectly about the ways in which they had coped with the impact of psychosis. Their accounts varied in terms of the strategies they used, but also in terms of their characterisations of themselves as protagonists. Some participants described themselves as active agents of change, attempting to minimise negative impacts or find positive perspectives on their experiences of psychosis. Others presented themselves as lacking agency, or as passive recipients of support or protection. Here, Graham shares with the interviewer his sense of control over his experiences:

**Interviewer: ...do you think it was drugs that made you feel better?**

Graham: The drugs helped (*okay*), but without sounding big-headed, I think it was myself.

**Interviewer: Yeah. No, I think that's fair enough. What do you think//**

Graham: //I made my own recovery.

**Interviewer: And how did you do that?**

Graham: Through my own determination and strength of will (*right, uh huh*) I'm in recovery (*yeah*). And now life is tolerable, tolerable. Not easy, but tolerable.

For some, there was clearly a strong or dominant self-story about how they coped with difficulty. For instance, here Michael talks about a pre-established way of 'coping' or 'dealing with' events or situations. Note the tone of passivity and the lack of resolution.

**Interviewer: So you don't feel that you're recovered. You feel that you're still dealing with a lot of these things, maybe at a lower intensity, but your kind of, ehm, strategy is to hold it all in and, and just wait and see if it, if it sorts itself out//**

Michael: //Yeah, that's always been my way of dealing with a lot of things, sort of since I was young (*right*). It's like, probably not the best way...



This was in contrast with others' self-stories; for example, Andrew described his dominant coping mechanism as '*keeping on the move*'. He presented himself as in control, and able to escape from or prepare for perceived dangers.

Andrew: I'd be up all night because I thought people would come through the door at night. So I was armed in the house (*okay*) wi' weapons, in case I got attacked...

The coping strategies that emerged included keeping oneself safe, self-nurturing, self-harming, making sense of experiences, receiving support, controlling the mind, building a life/preparing for the future, having faith, escape and avoidance, and accepting treatment. Each participant discussed a number of ways in which they had attempted to cope. Types of coping were linked to the 'genre' of the individual's narrative: for example, attempts to avoid thinking about or talking about experiences were associated with 'escape' narratives, while seeking to learn from experiences and effect change was associated with narratives of 'exploration and discovery'.

Participants described personal measures adopted to affect experiences of psychosis. These included changing one's circumstances, one's relationships, or one's own mind. The examples below illustrate these main categories of coping strategy. All shared a common theme of adaptation.

Jean: I stopped taking acid and ecstasy because people seemed to be betraying me, and - my, in my thoughts - seemed to be betraying me worse when I was on these kind of drugs (*right, okay*). So I just smoked hash, and people didn't seem to be as bad...

Gemma: I don't socialise with negative people.

**Interviewer: Right, okay. So you actively choose not to?**

Gemma: I actively choose not to (*uh huh*) because I think that doesn't help me. And if I do feel somebody's negative towards me or around me then I, I distance myself.

Andrew: ...sometimes I get hallucinations. Like I get, I hear people calling my name, or I hear people saying things they're not really saying (*yeah*). But I know they aren't really saying them, not at the time, but when I think about them (*yeah*), I'll think and think and think and say, "Maybe that's no happening, or maybe it's not." I control it in my own mind.

It is important to note that coping strategies chosen by participants varied widely, and that conflicting or seemingly incompatible strategies were observed between and within narratives.

For example, while Jean stopped using illicit drugs in an attempt to cope with her thoughts about others, Michael and Andrew both talked about using drugs to cope with their experiences.

Participants discussed the ways in which relationships had helped them to cope with the impact of psychosis. Kinds of support described were instrumental and socio-emotional. James, for example, talked about his sister *'taking me shopping and stuff like that, taking me down what I needed'*. Social support, such as providing company and listening, was also described. For example, Gemma talked about her mother and psychiatrist having *'been there for me when I needed them'*, and Michael remembered *'rambling on to my mum, sort of throughout the night, like, when I couldn't get to sleep'*. Emotional support was closely linked to the response of the individual's social world, with participants appearing to value non-judgemental, non-stigmatising attitudes.

Jean: ...he just helped me. He didn't hinder me in any way. He didn't make a fool of me.

**Interviewer: So how has he been great? How has he supported you?**

Laura: Um... by not judging terribly, but by not completely giving way to my opinions (*okay*). He's entitled to his own opinions (*uh huh*) and he's not scared to have them (*uh huh*). And that's useful for me (*yup*).

Some described actively seeking support from others, while other participants spoke of receiving support in a more incidental manner. It was common for participants to talk of having responsibility for managing the impact of psychosis by themselves, and they often appeared to perceive others as having limited ability or desire to understand or help them:

Michael: ...it must have been really hard for [my mum] because she didn't know what was going on (*yeah*) and it was just, she didn't really understand, but it, eh, it was just nice for her just to be there and be able to listen (*yeah*) but, eh, I suppose, like, ehm, there's not really much more she could've done.

James: I never asked anybody for any help, you know? My sister just kinda taken it upon herself, you know? (*Uh huh*) I just kinda plodded along. There's only so much they can gie you, you know? They cannae, they cannae stop this fae happenin' (*uh huh*), you know?

Thus, while due regard was given to the importance of social relationships, participants made it clear that they perceived themselves - regardless of their sense of control, confidence or wellbeing - as the main characters in their stories of adapting to psychosis.

### Stories of Escape, Entrapment, Endurance and Exploration

Four overarching ‘genres’ - or dominant storylines - emerged from the data: narratives of escape, entrapment, endurance/acceptance and exploration/discovery. Genres varied in how participants presented themselves as protagonists, the strategies they used to co-construct a shared understanding with the interviewer, and the ways in which they addressed key areas such as background experiences, relationships, self-perceptions and coping. As discussed previously, stories - and indeed genres - were not mutually exclusive. Thus, while a dominant genre could be discerned for each of the nine narratives yielded in this study, there was some overlap and amalgamation. Each genre will now be discussed in further detail, with illustrative quotations where appropriate.

#### *Narratives of Escape (The strong conqueror)*

Narratives of escape (Andrew, Graham) shared a focus on the physical or psychological distancing of the self from perceived sources of threat. Such threats appeared to be ‘live’ and cognitively and emotionally predominant, assuming forms such as paranoia and stigma. Background experiences used to contextualise the experience of psychosis were similarly described in terms of threat, and participants again seemed driven to distance themselves from these sources of endangerment. Relationships with others, in keeping with the theme of threat, were often perceived as persecutory or condemnatory. In an interpersonal sense, this was manifested in suspiciousness and lack of trust, and participants talked about strategies they used to protect the self from others, such as consciously improving one’s mental and physical health, and carrying weaponry. Participants’ defensive stance was also discernible in narratives through strategies such as ‘shutting down’ lines of questioning and limited reflectiveness.

Participants presented themselves as strong, capable protagonists, with the ability to conquer or overcome dangers posed to them. To convey this, they described coping strategies such as preparing oneself, remaining vigilant or ‘keeping on the move’. Narrative strategies could also be discerned, such as verbally distancing oneself from vulnerability or downplaying emotions. These strategies resulted in narratives with little interplay between perspectives or self-reflectivity.

Graham portrayed his symptoms themselves as a source of threat, describing ‘*terrible bad behaviour*’ and ‘*wrong*’ thoughts. He was at pains to distance himself from this description,

presenting himself as ‘*now completely normal*’ and his behaviour as ‘*perfect*’. Graham described himself as ‘*cured*’ by ECT and his own ‘*determination and strength of will*’. He presented this recovery with sparse detail, giving the impression of a simple, instantaneous event, rather than a complex process. Graham’s story lacked reflectiveness, and attempts by the interviewer to open up and unfold ideas were resisted. Sometimes, he appeared to divert conversation from the topic in question. Such narrative strategies allow an individual to separate him- or herself from undesirable states of perceived endangerment. In other words, Graham’s narrative allowed him to distance himself - and thereby to escape - from threatening experiences:

**Interviewer: How do you make sense of what’s happened to you? (...)**

Graham: I believe it’s a lot of mental illness (*right*). I believe it’s a mental illness and it’s cured.

**Interviewer: What kind of mental illness, do you think?**

Graham: I’d rather not talk about it.

**Interviewer: Okay, that’s alright.**

Graham: ECT cured it.

**Interviewer: Right, so it was cured by ECT?**

Graham: It was cured by ECT (...) Now I’m completely normal. Completely normal.

Graham: People sta-, people sort of look at you walking along the street. I’m not bothered, because I’m an old cripple. Anyhow, I got a haircut this week. I got a haircut.

Andrew’s transcript was suffused with descriptions of past, present and future perceived threats and dangers. He described an ongoing struggle to separate psychosis paranoia from ‘*real paranoia*’, i.e. a reality-based sense of threat. His extreme sense of endangerment had previously led to a number of behavioural coping strategies, which were a combination of ‘fight’ (readying oneself to overcome dangers) and ‘flight’ (avoiding or fleeing from dangers). Examples included carrying weapons, using drugs and ‘*getting drunk to cope with the illness that I had*’. Like Graham, Andrew used narrative strategies such as minimising, and his narrative was limited in terms of reflectivity. Reporting to feel ‘*a lot better*’ and expressing a wish to ‘*just get on wi’ my life*’, Andrew here talks about his plans for the future:

**Interviewer: And how do you see the future? What’s, what are things going to be like for you in the future?**

Andrew: I’m gonnae be less paranoid, but I’m gonnae still have my guard up, but I’m gonnae just kinda - - work it all out and go to different places, and just keep (*right*) on the move, and...

**Interviewer: So you're gonna keep on the move? (Aye) And is that to keep yourself safe?**

**(Aye) Right, okay.**

Andrew: That's how I cope wi' things.

**Interviewer: You just keep on the move?**

Andrew: Aye.

In both narratives, there was a tendency to present a singular perspective, or to leave discrepant perspectives unexplored. There was an overall sense of discomfiture about the experience of psychosis, and a lack of engagement with or curiosity about the experience. This led to a sense that the impact of psychosis remained unprocessed and unresolved.

#### *Narratives of Entrapment (The conflicted prisoner)*

Narratives of entrapment (Michael, Gemma) were distinguished by a consuming focus upon the impact of psychosis and dissatisfaction with current circumstances or situation. Participants seemed so preoccupied by loss and emotional pain that full processing of the experience and its consequences had not taken place. This lack of resolution and integration was also mirrored in accounts of background experiences and relationships, which were presented as ongoing sources of grief, emotional pain or discomfort. Narratives were distinguished by rumination and perseveration upon loss, dissatisfaction and negative emotional experiences. Conversely, positive experiences were minimised or diminished within the discourse.

Participants presented themselves as conflicted and incapable of resolving this. In discourse, this was demonstrated by their presentation of differing perspectives as irreconcilable. Narratives were therefore characterised by stagnation, hopelessness, and a sense of failure. A sense of internal conflict was also present in participants' perceptions of their relationships: they described ambivalent feelings, and a sense of strain or feeling 'torn' about engaging with or avoiding others. They compared themselves unfavourably with other people. It was notable that participants described few strategies for managing the impact of psychosis. This appeared to be linked to a generalised lack of agency in narratives: participants appeared to have little sense of control over their experiences. Coping strategies that *were* identified tended to focus on avoiding painful internal conflicts, and were described in terms of their failure, for example attempts to cut down on cannabis use, and suicide attempts.

Consider Gemma's self-perceptions in the following quotation. Here, she presents herself as not having been happy for a long time. Her narrative suggests that she experiences changes in

her mood as outwith her control. There is a sense of hopelessness, in that she perceives these changes as inevitable and cyclical:

Gemma: ...I go through a spell (*uh huh*) of - ehm - not, I wouldn't say happy, I, I wouldn't say I've ever been happy for a long time (*right, okay*). Just a spell of feeling not bad (*yeah, so coping okay*). And then all of a sudden I'll plummet (*uh huh*) and I'll just get worse.

**Interviewer: So then things just get worse. Okay. And that's just been the pattern, hasn't it?**

Gemma: My pattern.

Gemma talked about having had '*a very rough ride in life*', contrasting herself with friends, who were '*all married with children*'. Similarly, Michael compared himself with friends who were able to '*walk straight in to a job*' and '*guaranteed a job for life*', portraying his own qualifications as inferior. His narrative was dominated by a sense of failure and hopelessness. Consider his reflections on his use of cannabis:

Michael: I smoke a lot of grass (*uh huh*) and I have done for a long time (*yeah*). In certain respects, I quite enjoy it, and it's sort of, I would, could tell you that, you know, it's beneficial in certain ways (*uh huh*). But in a lot of other ways it's just really not very helpful at all: it's really detrimental (...) because I smoke so much of it I, and I feel as though I kind of can't go without it, sort of thing (*right*). Ehm - - and - - ehm, yeah, in the last couple of years I've kind of wanted to maybe try and do something about that, but most of the time I've not been able to. But whenever I do kind of stop, or do kind of cut down or whatever (*yeah*), it leaves me feeling quite - - vulnerable, because I find that with it, it kind of helps me to block out a lot of kind of (*right*) emotional stuff that is sort of, really builds up over time...

Michael's account highlights a key feature of narratives of entrapment: the use of coping mechanisms that actually maintain or exacerbate participant's undesired circumstances. The pervasive conflict of narratives is demonstrated by Michael's presentation of the relative merits and disadvantages of cannabis use, and the lack of resolution in his feelings about this.

#### *Narratives of Endurance and Acceptance (The scarred survivor)*

In narratives of endurance and acceptance (James, Jean, Lindsay), the experience of psychosis was described and its various impacts acknowledged. Also described were attempts made by the individual to adapt self, relationships and circumstances in order to integrate the experience and move forward. There was an overarching sense of experiences being processed; this was

reflected behaviourally by coping strategies that minimised the impacts of psychosis - such as engagement with sources of support - and maximised progress towards a desirable future, such as seeking employment or educational opportunities. In narratives, processing was denoted by acknowledgement of the discrepancy between hopes and reality, without a sense that this preoccupied individuals or was perceived as an impasse to growth and wellbeing. Consider Jean's determination to move forward in spite of her difficulties:

Jean: I feel optimistic for the future, and you know, instead of shying away from people because I'm, I've got a mental illness, I'm gonna, you know, just grab the bull, grab the - what's it?

**Interviewer: Grab the bull by the horns?**

Jean: The horns! And, and make friends when I, when I get my new house (...) That's what I want to do. I'm positive about the future...

Participants who told stories of endurance and acceptance presented themselves as having both strengths and weaknesses, with narratives including positive achievements and struggles. Individuals portrayed themselves as active agents for change in their own stories. They recognised their power to effect change, while acknowledging the limits of their control. Relationships were depicted as a source of support, but without absolute dependency. As with the experience of psychosis, background experiences were described and their impacts discussed, but generally without a sense of preoccupation or ongoing pain.

The theme of acceptance is clearly illustrated by this excerpt from James' narrative, in which he talks about his hopes for the future, while addressing the possibility that they may remain discrepant from reality. James also talked about his involvement in courses at college, his goal to get a job, and his plan to achieve this by volunteering initially. This presentation of goals alongside plans for achieving them was characteristic of 'endurance/acceptance' narratives, lending them a sense of optimism and credibility. Notice James' willingness to accept support from others (Mental Health Services and his General Practitioner) but also his sense of having personal control over his situation:

James: I'm doing everything I can (*yeah*). I mean, like, I'm off caffeine from, like, six o' clock at night (*right*), you know? I'm doing my relaxation stuff... Eh, I'm taking my, see, my medication (*yeah*), you know? (...)

**Interviewer: Yeah. So you're kind of doing all the right things?**

James: Well, this is it. I've always tried to do that anyway (*uh huh*), you know? It's just I try to, I try to do what they say, you know what I mean? (*Yup*) Because obviously it's, it's there to help, you know?

**Interviewer: Yeah. And what do you think would be your recovery?**

James: Eh, well basically I would hope to, it stopped altogether (*yup*), you know? But I've, I've just - - it's - - I've actually come to accept that it might not (*yeah*), do you know what I mean?

Narratives of endurance and acceptance shared processes of adaptation and integration of experiences. These processes were observed across key areas of experiences, relationships and self-perceptions. For example, Lindsay talked about how she had come to recognise the way in which her marriage had contributed to her sense of unhappiness and to the experience of psychosis. She talked about the changes that were taking place in terms of her sense of self and her social positioning:

Lindsay: [In hospital] I've had an awful lot of people talking to me (*mm hmm*) and listening to me, and you get as many cuddles as you want. Um...

**Interviewer: And what do you think that's done for you?**

Lindsay: . . . {{3 seconds}} It's, ehm - - made me feel . . . . {{4 seconds}} I don't know, 'wanted', or 'needed', or kinda - - I don't know. I don't know if it's 'cherished' or I don't know (*okay*) . . . {{3 seconds}} 'appreciated', maybe (*yeah*)?

Overall, these characteristics formed open, discursive narratives, with high levels of reflection and integration or resolution between alternative perspectives. While participants did not describe complete abatement of clinical symptoms, they appeared to have been able to establish or re-establish a sense of movement and growth in spite of ongoing challenges.

#### *Narratives of Exploration and Discovery (The enlightened explorer)*

Narratives of exploration and discovery (Jeffrey, Laura) portrayed psychosis as a learning experience, through which individuals had gained insight into their experiences, and a greater understanding of themselves. Participants gave a picture of themselves as enthusiastic and intrepid travellers into the uncharted territories of psychosis: this was exemplified in narratives by a stance of curiosity, openness to experience, and an emphasis on the positive impacts of the experience of psychosis. In keeping with the sense of discovery, participants expressed a sense of personal growth and enlightenment about themselves, others and their experiences, which appeared to have been achieved through the process of exploration. Even within the course of the narrative, this evolution could be discerned and was remarked upon by participants:



Laura: I mean, yeah, if you go way back, yeah, it was a little bit scary, obviously, things going on (*uh huh*). Um, but now I feel, and I hate saying ‘enlightened’ because it puts all sorts of religious connotation on it, and, and there is none (...) But enlightened (*yeah*) and at home, at ease, at comfort.

Compared with some other genres, there was a greater sense of psychological ease in relation to experiences and relationships in narratives of exploration and discovery. This was revealed in narratives by an absence of preoccupation or intense emotion, and by reflectiveness and acceptance of how experiences had affected self-development. Experiences and relationships were understood by participants - quite apart from having had both positive and negative impacts - as having played an important role in constructing identity. Consider Jeffrey’s understanding of his experiences as a vehicle to his present situation and identity:

**Interviewer: So looking back now (*yes*) on those experiences that you’ve talked about (*yes*), how do you make sense of them?**

Jeffrey: . . . . {{4 seconds}} How do I make sense of them? I think, as I sit here now, I feel I don’t have to make sense of them. They are what they are; they’ve brought me here (*mm hmm*) - they brought me down the path. There’s a very famous book called ‘The Road Less Travelled’ (*yup*), which I haven’t read (*neither have I*), but I feel as if I’ve been on the road *much* less travelled!! {{Laughs}}

Coping strategies included questioning habitual ways of being, and trying alternatives. It was as though the experience of psychosis had inspired new perspectives and new prospects. Participants, in turn, seemed open to considering or trying new ways of considering themselves, their relationships and their experiences:

Jeffrey: I reached a stage, having always followed the rules in my life (*yeah*) - I’ve always been a follower of rules to, to a fault, and it *is* a fault, because it’s you, you know, rules are there to be broken once in a while, yeah? (*Uh huh*) But I have been the perfect son, the perfect husband, the perfect father, you know? (*Yeah*) I’ve done all these things, but it still wasn’t good enough (...) and then I just, because basically I reached a point where I thought, “f\*\*\* it” (*uh huh*) “I’m just gonna go with the flow, see where this takes me.”

**Interviewer: Could I ask you to reflect a wee bit on how you feel about your life now, and h-, and in the future?**

Jeffrey: - - right. The last six weeks have been the most stimulating and interesting of my life. I've laughed more and I've cried more in the last six weeks than I have in my life (*mm hmm*). I've met more interesting people and more soul mates in the last six weeks than I have in the rest of my life (*mm hmm*) (...) And I'm - - happier now than I've ever been.

In general, narratives of exploration and discovery shared a stance of optimism and excitement. Participants talked about approaching the future with a sense of exploration and interest. While some questions remained unanswered for these 'enlightened explorers', this uncertainty was not portrayed a source of fear or stress as it was in other genres.

## **Discussion**

The initial point of departure for the current study was to explore participants' narratives about experiences of psychosis and recovery. It was hoped that insights provided by the study would inform the development of narrative-based approaches to evaluating recovery and adaptation following psychosis. Semi-structured interviews provided rich and nuanced narratives describing how participants appraised and responded to psychotic experiences, both initially and over time. A Social-Constructionist Grounded Theory analysis of the content and form of participants' narratives gave a valuable insight into the processes underpinning adaptation to, or recovery from, psychosis. Across all interviews, a core process of storytelling emerged, by and through which participants 'charted the landscape of psychosis'. This process was characterised by 'resounding echoes' or patterns, and attempts to reconcile multiple stories and perspectives. To establish a shared understanding of their experiences with the interviewer, participants provided contextual information about self-perceptions, interpersonal relationships, and background experiences. These factors were portrayed as affecting participants' entry to, journey through, and - sometimes - exit from, psychosis. Through accounts, it became clear that they both affected and were affected *by* the storytelling process. As such, the storytelling process appeared to play a role in identity construction, social positioning and adaptation to experiences. Participants made efforts to describe the pervasive impact of psychosis and attempts to cope. The initial Grounded Theory approach was supplemented by a Narrative Analysis approach, informed by the central process of storytelling. This provided an opportunity to extend the Grounded Theory analysis and approach the data in a new light. While there was some degree of overlap between stories between and within narratives, it was possible, using Narrative Analysis methodologies, to characterise genres of escape, endurance, entrapment and

exploration, and self-characterisations of ‘The Strong Conqueror’, ‘The Conflicted Prisoner’, ‘The Scarred Survivor’ and ‘The Enlightened Explorer’.

The central storytelling process apparent in participants’ narratives appeared to play a role in identity construction, social positioning, and adaptation, and thereby to facilitate ‘making sense of’ experiences of psychosis. This supports social-constructionist theories, which posit the existence of a drive to understand or attribute meaning to experiences, and narrative theories, which suggest that these meaning-making processes are propagated by narrative production. Roe and Davidson (2005) have described the re-construction of individuals’ life stories following psychosis as a central component of the recovery process, rather than an outcome or by-product of recovery. The results of this study support this conceptualisation, with storytelling appearing as both contributing to and influenced by meaning-making processes, and, in turn, personal and social identities, and adaptation. This identifies a need for the development of psychotherapeutic approaches that promote reflection and meaning-making about experiences of psychosis through the recovery-congruent process of narrative production.

A growing body of research has conceptualised narrative production as an explorative process. Pals (2006) defined exploratory narrative processing as *‘an active, engaged effort on the part of the narrator to explore, reflect on, or analyse a difficult experience with an openness to learning from it and incorporating a sense of change in to the life story’* (p.1081). She argued that coherent positive resolution - *‘the construction of a coherent and complete story of a difficult event that ends positively, conveying a sense of emotional resolution or closure’* - may be associated with subjective wellbeing. There is evidence to support this proposition. McAdams, Reynolds, Lewis, Patten and Bowman (2001) showed that a higher volume of redemption sequences, wherein a negative experience is followed by a positive outcome, in an individual’s life narrative was associated with higher scores on measures of subjective wellbeing. In the current data, the core process of storytelling appeared to be in dynamic interplay with relationships, self-perceptions and experiences. Open reflection upon the experience of psychosis and the reconciliation of multiple selves and perspectives was associated with genres of endurance/acceptance and exploration/discovery. In keeping with the findings of McAdams *et al.* (2001), these narratives were characterised by a greater sense of positivity, optimism, movement and growth.

Narrative and dialogical approaches share a focus on the construction of meaning through discourse, and it has been proposed that this process, promoted within a psychotherapeutic relationship, can mediate individuals’ experiences of distress (Dilks, Tasker & Wren, 2008).

Dialogical approaches conceptualise the self as being composed of multiple 'self-voices', and identity as being constructed by internal and external dialogues. It has been proposed by some that psychotherapy serves to enhance interplay between self-voices (Georgaca, 2001; Stiles, 1999). Lysaker and colleagues have suggested that changes in self-perception associated with psychosis may be due to collapse in this interplay, and that restitution of internal and external dialogues may facilitate recovery. Lysaker and Buck (2006) discuss how best, in psychotherapy, to support individuals adapting to experiences of psychosis. They argue that recovery-focused psychotherapy should be non-hierarchical, aiming to facilitate the individual's creation of a personal narrative, rather than providing this.

The data and findings detailed here have important implications for working clinically with individuals who have experienced psychosis. If an individual's narrative and the process of storytelling reflect the way in which he or she copes with experiences and constructs an account to make sense of them, then a key implication is that phenomena described therein are an expression of the process of adaptation. Narratives and storytelling represent a crucial vehicle of communication between an individual and his or her social world. The stories told by individuals, and the way in which they are told, shape the way in which others understand and respond to them. Thus, elements contained within and through stories, such as expression of symptoms and narrative strategies, can themselves be understood as epiphenomena of an underlying process of meaning-making and adaptation. For example, a symptom such as paranoia might be understood as an effective defence against danger, in the context of a story of threat. Similarly, a narrative strategy such as closing down or avoiding dialogue about emotionally threatening material represents a form of defence. As such, scrutiny of the interplay between an individual's clinical presentation and processes of meaning-making and adaptation may offer clinicians clear pointers for intervention. This lends credence to the formulation-based approach often favoured by clinical psychologists (c.f. Morrison, Renton, Dunn, Williams & Bentall, Eds., 2004) and raises further questions about the therapeutic utility of diagnostic categorisation. It makes sense of evidence that subjective experiences of recovery and social/functional outcomes are often discrepant with clinical and occupational outcomes (Lieberman *et al.*, 2002; Scottish Recovery Network, 2007). Crucially, it recognises the value of symptoms as vessels of information to facilitate the therapist's attunement, and suggests that the emphasis on eliminating symptoms is misplaced. Rather, individuals may be assisted in 'recovery' - or adaptation - by the facilitation of storytelling opportunities, which provide a means for participants to reconcile multiple stories and perspectives, and contribute to identity construction, social positioning and adaptation.

Narratives ranged from largely descriptive, factual and non-reflective accounts to accounts that considered multiple perspectives and incorporated reflectiveness. In this study, four 'genres' of narrative were identified, each associated with its own profile. This suggests that an individual's adaptation to psychosis, or 'recovery style' is more subtle and nuanced than the broad distinction made by McGlashan (1975). Data resonated with theories of attachment. Bowlby (1973) proposed that, through interactions with attachment figures, the infant develops 'internal working models', which are used to understand and respond to him- or herself, other people and the environment. Thus, early attachment relationships provide an internal framework by which the individual understands and responds throughout the lifespan. An individual's 'recovery style' can therefore be understood to represent a more general pattern of processing and responding information, rooted in early attachment experiences. In keeping with the notion of attachment as being crucial in determining perceptions and responses, the data were permeated with material related to relationships, both with others, but also between multiple selves, perspectives and experiences. Within each interview, there were resounding 'echoes', or patterns, which were inextricably linked with the individual's interpersonal world.

### *Limitations*

Exploration of recovery from psychosis in this study was based on the narratives of nine participants, and the researcher's interpretations of these. As discussed above, it is acknowledged that these interpretations represent only one possible construction of the data, rather than an exhaustive or absolute characterisation. To ensure fidelity and credibility, the process of analysis - including validation of emergent conceptualisations and themes - was overseen by a research supervisor, with experience in qualitative techniques. In order to maximise the transparency of analysis, excerpts of narratives have been provided to illustrate and justify interpretations. Provision of quotations further allows the reader to arrive at a personal understanding of the data. It is appreciated that other approaches could have been employed to examine and interpret data.

Respondent validation may have been a desirable adjunct to this study. In another study examining narratives of recovery from psychosis, Thornhill *et al.* (2004) invited participants to contribute comments to the developing analysis of their narratives. They reported that this both offered legitimacy to their findings and added to their interpretation of data. However, such approaches have been criticised by some authors as reducing research to a checklist of analytical procedures (Barbour, 2001). Willig (2001) cautions that qualitative research is rooted in creative and reflective - rather than mechanistic or formulaic - processes.

## Conclusions

This study represents a qualitative exploration of recovery and adaptation following psychosis using complementary methodologies. Social-Constructionist Grounded Theory focused on exploring how individuals experience and make sense of the world, acknowledging the mutual roles of participant and researcher in co-constructing an understanding of this. From the data emerged a core process of storytelling, by which participants ‘charted the landscape of psychosis’. The process of storytelling influenced and was influenced by relationships and social positioning, self-perceptions and identity construction, and background experiences and adaptation. Across participant narratives, there were themes of ‘resounding echoes’, ‘reconciling multiple stories and perspectives’, ‘describing the impact of psychosis’ and ‘managing the impact of psychosis’. Narrative Analysis allowed further examination of the data, according to the kinds of stories told by participants. Four broad genres of story and protagonist characterisation were identified: stories of escape, narrated by ‘strong conquerors’, stories of entrapment, narrated by ‘conflicted prisoners’, stories of endurance/acceptance, narrated by ‘scarred survivors’, and stories of exploration/discovery, narrated by ‘enlightened explorers’. The complexities of experiences were evident in the multiple and multidirectional layers of influence depicted by narratives. As such, it is argued that clinicians should adopt a formulation-based approach, which conceptualises symptoms as expressions of adaptation, and places an emphasis on enhancing this process, rather than attempting to eliminate clinical symptoms. This may be achieved through the development of psychotherapeutic interventions that promote storytelling, thereby facilitating reflection and integration of experiences including psychosis, and contributing to ongoing identity construction, social positioning and adaptation.

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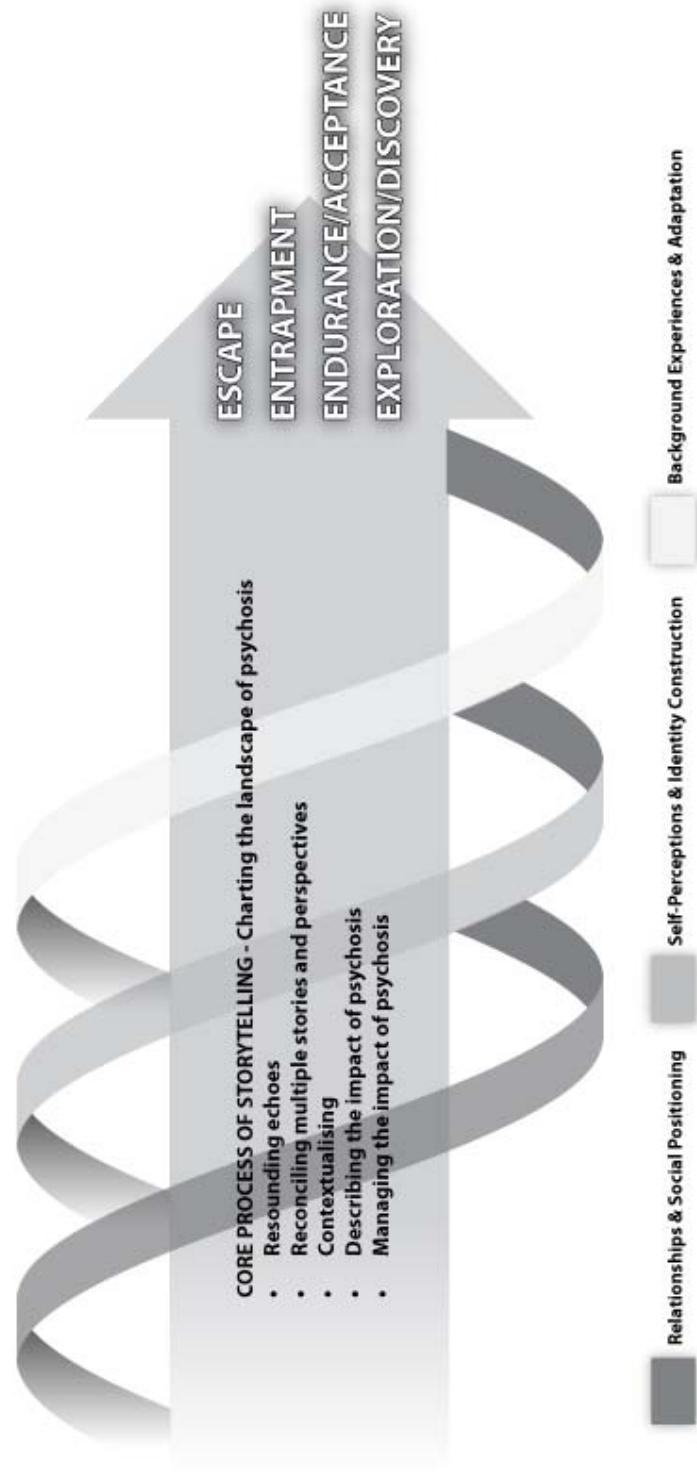
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**Table 1: Participant Characteristics**

<b>Name</b>	<b>Gender</b>	<b>Age</b>	<b>Diagnosis</b>	<b>Hospitalisations</b>
Andrew	M	28	Schizophrenia	2+
Gemma	F	38	Major Depression with Psychotic Features	2+
Graham	M	67	Schizophrenia	2+
James	M	31	First Episode Psychosis	0
Jean	F	30	Schizoaffective Disorder	2+
Jeffrey	M	44	Bipolar Affective Disorder	1
Laura	F	26	Bipolar Affective Disorder	1
Lindsay	F	42	Major Depression with Psychotic Features	1
Michael	M	25	First Episode Psychosis	0

Figure 1: Summary of Findings

# Narratives of Adaption and Recovery Following Psychosis



## **CHAPTER 3**

### **REFLECTIVE CRITICAL ACCOUNT, ADVANCED PRACTICE I (ABSTRACT ONLY)**

#### **Learning to Manage the Emotional Impact of Exposure to Distressing Material**

## ABSTRACT

Clinical Psychology trainees are required to develop and demonstrate advanced critical reflective skills, in preparation for the Clinical Psychologist's key role as a 'reflective practitioner'. In this paper, I reflect on the ongoing emotional impact of working in a specialist mental health service for Looked After and Accommodated children and adolescents. I describe my attempts to manage this emotional impact, and the 'reflective spiral' through which I have progressively reflected in and upon my actions. Mindful of evidence that reflective practice is rendered more potent when structured around a theoretical model, I use Johns' (2004) reflective model to reflect upon my experiences. I detail how these experiences and reflections have contributed to my professional development in the key areas of ethics, communication and clinical practice identified in the National Occupational Standards for Clinical Psychologists (BPS, 2002). I also attempt to place my reflections in the wider service and professional contexts. Finally, I consider the limitations of current reflective frameworks and how to optimise my own reflective practice.

## **CHAPTER 4**

### **REFLECTIVE CRITICAL ACCOUNT, ADVANCED PRACTICE II (ABSTRACT ONLY)**

#### **The Act of Not Acting**



## ABSTRACT

The National Occupational Standards for Clinical Psychologists (BPS, 2002) detail generic key roles to be fulfilled by the practising Clinical Psychologist. As part of Clinical Psychology training, trainees are required to evidence professional development through written reflections related to these domains. In this account, I consider an exchange with my supervisor in which I failed to disclose a difference of opinion. I use Brookfield's (1995) 'four lens' model to reflect critically upon my non-action, examining the incident from autobiographical, theoretical, peer/colleague and learner/supervisee perspectives. I relate my reflections to the key roles of the Clinical Psychologist, and detail how my experience has contributed to my professional development in the areas of training and management. I evaluate the process of reflection, place it in the context of my evolving reflective practice, and detail the ways in which the reflective process has influenced my plans for future professional development.

## **APPENDIX 1.1**

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## **APPENDIX 2.1**

### **GUIDELINES FOR SUBMISSION TO CLINICAL PSYCHOLOGY & PSYCHOTHERAPY**





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**Assessments:** Articles reporting useful information and data about new or existing measures.

**Practitioner Reports:** Shorter articles that typically contain interesting clinical material.

**Book Reviews:** Published on invitation only. Critical summaries of recent books that are of general interest to readers of the journal.

**Reference style.** The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

**A. A typical citation of an entire work consists of the author's name and the year of publication.**

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

**B. If the author is named in the text, only the year is cited.**

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

**C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.**

Example: In a 1989 article, Gould explains Darwin's most successful. . .

**D. Specific citations of pages or chapters follow the year.**

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

**E. When the reference is to a work by two authors, cite both names each time the reference appears.**

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

**F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al.* (meaning "and others").**

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al.*, 1997). When the reference is to a work by six or more authors, use only the first author's name followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

**G. When the reference is to a work by a corporate author, use the name of the organization as the author.**

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

**H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.**

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

**I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.**

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

#### **Journal Article**

Gardikiotis, A., Martin, R., & Hewstone, M. (2004). The representation of majorities and minorities in the British press: A content analytic approach. *European Journal of Social Psychology*, 34, 637-646. DOI: 10.1002/ejsp.221

## Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

## Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean*. Hartford, CT: Univ. of Hartford Press.  
Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world*. Hartford, CT: Capital Press., and so on.

The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

## Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials*. Retrieved May 18, 2000, from Vanguard University, Dept. of Psychology Website:  
[http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc\\_id=796](http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796)

## Stand-alone Web Document (no date)

Nielsen, M. E. (n.d.). *Notable people in psychology of religion*. Retrieved August 3, 2001, from <http://www.psywww.com/psyrelig/psyrelpr.htm>

## Journal Article from Database

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence*, 15, 503-522. Retrieved May 20, 2000, from ProQuest database.

## Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology*, 20, 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

## Article or Chapter in an Edited Book

Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press.

\*The Digital Object Identifier (DOI) is an identification system for intellectual property in the digital environment. Developed by the International DOI Foundation on behalf of the publishing industry, its goals are to provide a framework for managing intellectual content, link customers with publishers, facilitate electronic commerce, and enable automated copyright management.

**Illustrations.** Upload each figure as a separate file in either .tiff or .eps format, the figure number and the top of the figure indicated. Compound figures e.g. 1a, b, c should be uploaded as one figure. Grey shading and tints are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Where a key to symbols is required, please include this in the artwork itself, not in the figure legend. All illustrations must be supplied at the correct resolution.

- Black and white and colour photos - 300 dpi
- Graphs, drawings, etc - 800 dpi preferred; 600 dpi minimum
- Combinations of photos and drawings (black and white and colour) - 500 dpi

The cost of printing **colour** illustrations in the journal will be charged to the author. The cost is approximately £700 per page. If colour illustrations are supplied electronically in either **TIFF** or **EPS** format, they **may** be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the *Wiley InterScience* site.

## **APPENDIX 2.2**

### **EVIDENCE OF ETHICAL APPROVAL FOR STUDY**

## Primary Care Division

Research Ethics  
Primary Care, Community & Mental Health REC  
R&D Directorate  
1<sup>st</sup> Floor – The Tennent Institute  
Western Infirmary  
38 Church Street  
Glasgow G11 6NT  
[www.nhsrgc.org.uk](http://www.nhsrgc.org.uk)



Ms Beatrice Anderson  
Trainee Clinical Psychologist  
Department of Psychological  
Medicine  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow G12 0XH

Date 09 February 2009  
Your Ref  
Our Ref  
Direct line 0141 211 2123  
Fax 0141 211 2811  
E-mail [Liz.Jamieson@ggc.scot.nhs.uk](mailto:Liz.Jamieson@ggc.scot.nhs.uk)

Dear Ms Anderson

**Full title of study:** Understanding Recovery from Psychosis:  
Developing a Narrative Recovery Scale  
**REC reference number:** 08/S0701/173

The Research Ethics Committee reviewed the above application at the meeting held on 05 February 2009.

### Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

- Please confirm that consent will be received from both the patient and the RMO before you proceed.

The favourable opinion is not valid until the above point is confirmed to the Committee Co-ordinator.

### Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the



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Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

### Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Student's CV		
Referees Report		12 December 2008
Advertisement	Version 1	12 January 2009
Interview Schedules/Topic Guides	Version 1	12 December 2008
Covering Letter		12 December 2008
Protocol	Version 1	12 December 2008
Investigator CV		
Application		12 December 2008
Response to Request for Further Information		21 January 2009
Participant Consent Form: Version 2		21 January 2009
Participant Information Sheet: Version 2		21 January 2009

### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

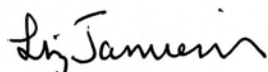
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

**08/S0701/173**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



**Liz Jamieson**

**Committee Co-ordinator on behalf of Dr Paul Fleming, Chair**

Enclosures:      List of names and professions of members who were present at the meeting  
"After ethical review – guidance for researchers"  
Site approval form (SF1)

Copy to:            Mr Brian Rae



## Glasgow & Clyde Primary Care, Community & Mental Health

### Attendance at Committee meeting on 05 February 2009

#### Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Liz Jamieson	Committee Co-ordinator	Yes	
Winifred McCartney	Assistant Co-ordinator	Yes	
Dr Jacqui Anderson	Consultant Psychiatrist	Yes	
Dr Janet Brennand	Consultant Obstetrician	Yes	
Dr Jim Brooks	Lay Member	No	
Dr Adam Burnel	Consultant Psychiatrist	No	
Ms Lorna Cuthbertson	Senior Clinical Pharmacist	Yes	
Mr Paul Davies	Principal Pharmacist	Yes	
Dr Paul Fleming	Consultant Clinical Psychologist	Yes	
Mr Martin Hattie	Clinical Nurse Specialist	Yes	
Mr Eoin MacGillivray	Lay Member	Yes	
Dr Robert McNeil	General Practitioner	Yes	
Mrs Gillian Notman	Joint Occupational Therapy Lead Advisor	Yes	
Mrs Helen Ross	Lay Member	No	

# Glasgow & Clyde Primary Care, Community & Mental Health

## LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

<b>REC reference number:</b>	08/S0701/173	<b>Issue number:</b>	0	<b>Date of issue:</b>	09 February 2009
<b>Chief Investigator:</b>	Ms Beatrice Anderson				
<b>Full title of study:</b>	Understanding Recovery from Psychosis: Developing a Narrative Recovery Scale				
This study was given a favourable ethical opinion by Glasgow & Clyde Primary Care, Community & Mental Health on 05 February 2009. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.					
<b>Principal Investigator</b>	<b>Post</b>	<b>Research site</b>	<b>Site assessor</b>	<b>Date of favourable opinion for this site</b>	<b>Notes <sup>(1)</sup></b>
Ms Beatrice Anderson	Trainee Clinical Psychologist	NHS Greater Glasgow and Clyde	Glasgow & Clyde Primary Care, Community & Mental Health	09/02/2009	
<p>Approved by the Chair on behalf of the REC:</p> <p>.....<i>Dr. Jameson</i>..... (Signature of Chair/Co-ordinator)  (delete as applicable)</p> <p>.....<i>LIZ JAMESON</i>..... (Name)</p>					

Primary Care Division

Research Ethics  
Primary Care, Community & Mental Health REC  
R&D Directorate  
1<sup>st</sup> Floor – The Tennent Institute  
Western Infirmary  
38 Church Street  
Glasgow G11 6NT  
[www.nhsqgc.org.uk](http://www.nhsqgc.org.uk)



Ms Beatrice Anderson  
Trainee Clinical Psychologist  
Department of Psychological  
Medicine  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow G12 0XH

Date 09 February 2009  
Your Ref  
Our Ref  
Direct line 0141 211 2123  
Fax 0141 211 2811  
E-mail [Liz.Jamieson@ggc.scot.nhs.uk](mailto:Liz.Jamieson@ggc.scot.nhs.uk)

Dear Ms Anderson

**Full title of study:** Understanding Recovery from Psychosis:  
Developing a Narrative Recovery Scale  
**REC reference number:** 08/S0701/173

I refer to your letter dated 12<sup>th</sup> February 2009 in response to my letter dated 9<sup>th</sup> February 2009.

I can confirm that you have now met the conditions of the favourable opinion letter and that your ethical approval is now valid.

Yours sincerely

A handwritten signature in black ink that reads 'Liz Jamieson'.

**Liz Jamieson**  
**Research Ethics Co-ordinator**

Copy to R&D for information



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## **APPENDIX 2.3**

### **EVIDENCE OF MANAGEMENT APPROVAL FOR STUDY**

## Acute Services Division

Coordinator/administrator: Dr Darren Gibson  
Telephone Number: 0141 211 8551  
Fax Number: 0141 211 2811  
E-Mail: [Darren.Gibson@ggc.scot.nhs.uk](mailto:Darren.Gibson@ggc.scot.nhs.uk)



R&D Management Office  
Western Infirmary  
Tennent Institute  
1st Floor, 38 Church Street  
Glasgow, G11 6NT

03 April 2009

Ms Beatrice Anderson  
Trainee Clinical Psychologist  
Department of Psychological Medicine  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow  
G12 0XH

### R&D Management Approval

Dear Ms Anderson

**Project Title: Understanding Recovery from Psychosis: Developing a Narrative Recovery Scale**  
**Chief Investigator: Ms Beatrice Anderson**  
**R&D Reference: PN08CP536**  
**Protocol no (including version and date): version 1, dated 24<sup>th</sup> November 2008**

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Management Approval** for the above study.

As a condition of this approval the following information is required during the lifespan of the project:

1. SAES/SUSARS – If the study is a **Clinical Trial** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004 (CTIMP only)
2. Recruitment Numbers on a quarterly basis (not required for commercial trials)
3. Any change of Staff working on the project named on the ethics form
4. Change of CI
5. Amendments – Protocol/CRF etc
6. Notification of when the Trial / study has ended
7. Final Report
8. Copies of Publications & Abstracts

**Please add this approval to your study file as this letter may be subject to audit and monitoring.**

Yours sincerely

A handwritten signature in black ink, appearing to read 'Darren Gibson', written over a light blue horizontal line.

Dr Darren Gibson  
Research Co-ordinator

*Delivering better health*

[www.nhsggc.org.uk](http://www.nhsggc.org.uk)

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## **APPENDIX 2.4**

### **RECRUITMENT ADVERTISEMENT**

## ***Psychosis: Your Personal Story***

I am a researcher who is conducting a study about personal experiences of recovery from psychosis. I am interested in speaking to individuals who have experienced psychosis, to learn more about their personal stories of recovery.

### ***What is the research study about?***

Recovery can be very different for each person who has experienced psychosis. Research suggests that important indicators of a person's recovery might include how they think and feel about their experiences. Clues to this can be found in their personal story about the experience of psychosis (e.g. whether or not they feel valued and supported). In this study, I am trying to develop a system that uses personal stories to understand a person's recovery.

### ***Why is this research important?***

If we can understand a person's recovery better, then it may be possible to develop new psychological therapies to help people in the recovery process.

### ***What is involved?***

I will aim to meet you for two one-hour sessions at the base of the mental health service where you receive treatment. I will ask you about your experience of psychosis. There are no right or wrong answers: I am interested in your personal story. You will be given a one-off payment of £5 to cover travel expenses.

### ***What happens next?***

If you are interested in taking part, please fill in the slip below, and return it in the freepost envelope provided. When I receive your slip, I will phone you to have a chat and answer any questions you may have.

It is important to be sure that your participation does not interfere with any ongoing treatment you may be receiving. I would like to contact your key-worker and psychiatrist to confirm your diagnosis and check that your involvement will not affect your treatment. Please complete the tear-off slip below if you would like to participate, and are happy for me to contact your key-worker and psychiatrist.

Thank you for taking the time to read this information.

---

NAME:

TELEPHONE NUMBER:

KEYWORKER'S NAME:

SIGNATURE:

(I am happy for you to contact my key-worker and psychiatrist)

[Name of mental health service will be added here prior to advertisement]

## **APPENDIX 2.5**

### **PARTICIPANT INFORMATION SHEET**



A Study of Personal Experiences of Psychosis  
Participant Information Sheet: Version 2 (21/01/09)

I would like to invite you to take part in a research study. My name is Bea Anderson, and I am a Trainee Clinical Psychologist. I am interested in hearing personal stories about recovery from psychosis. Before you decide if you would like to take part, it is important for you to understand why I am doing the study, and what it would involve for you. Please read this information carefully, and discuss it with other people if you wish.

**What is psychosis?**

‘Psychosis’ is a term that has been used to describe a group of different experiences, which might include unusual perceptual experiences (e.g. hearing voices), unusual beliefs, extreme emotions (e.g. depression, elation or even both at the same time), listlessness and lack of motivation.

**What is the research about?**

Recovery can look and feel very different for each person who has experienced psychosis. In order to decide whether someone has recovered from psychosis, mental health services often look at clinical outcomes (e.g. whether or not the person is still having unusual perceptual experiences) or occupational outcomes (e.g. whether the person can go back to work). However, research suggests that important indicators of a person’s recovery might also include how they think and feel about their experiences. Clues to this can be found in their personal story about the experience of psychosis (e.g. whether or not they feel valued and supported).

In this study, I aim to develop a system that uses personal stories to understand a person’s recovery. I am interested in hearing about people’s experiences of psychosis, and how it affected their lives. This kind of research can help mental health services to understand the needs of people who have experienced psychosis, and to develop new psychological therapies that aim to help people recover.

**Who is being asked to take part?**

I am asking people who have experienced psychosis in the past to take part in the study.

**Do I have to take part?**

No. It is your choice whether or not to take part in the study. If you would like to take part, you will be asked to sign a consent form, to make sure that you understand what you have agreed to. However, if you change your mind later, you can withdraw from the study and you do not have to give a reason.

**What will happen next?**

If you are interested in taking part, please fill in the slip, place it in the envelope provided and hand the sealed envelope to the receptionist. I will then phone you to have a chat and arrange to

meet you. I will ask your permission to contact your key-worker and psychiatrist, to confirm your diagnosis and ensure that taking part will not affect your treatment. You are welcome to meet me first with a friend, family member or your key-worker. I will meet you at the base of the mental health service that provides your treatment. After this, I will give you at least 24 hours to decide whether you want to take part in the study. If you still want to participate, then you and I will make arrangements to meet again.

### **What would I have to do if I take part?**

In our first chat on the phone, I will answer any questions or concerns you might have. I will then arrange to meet with you on two separate occasions for approximately one hour, but this is flexible, depending how you find the experience. During these meetings, I will chat to you about your experience of psychosis. There are no right or wrong answers. I am interested in hearing your personal story of psychosis: how it felt for you. Our second meeting will be tape-recorded, so that I can remember your story fully. I will then transcribe our conversation and destroy the tape-recording.

### **What is the down side of taking part?**

It is possible that it will be difficult or upsetting for you to talk about your experiences of psychosis. If you do not want to continue, you can end the meeting at any time. I would also like to meet at a time when your key-worker is available, so that you can speak to someone who knows you if you need to.

### **What is the up side of taking part?**

There are no direct benefits to you of taking part in the study. However, what we learn from this study will help us understand recovery better and develop new therapies to help people recover.

### **Will my taking part be kept confidential?**

Yes. The information you provide me with will be treated confidentially. All recordings and transcriptions will be stored on a password-protected computer. Your name and any information that could identify you will not appear in any reports. I will ask for your consent to use quotations from our conversation in reports about the research.

If you share information that makes me concerned for your safety or the safety of other people, I may be required to tell others involved in your care (e.g. your key-worker or psychiatrist). I will always notify you beforehand if I am going to do this, and explain why.

### **What will happen to the results of the study?**

I will provide you with a summary of the results of the study. The final results and conclusions of the study will be published in a scientific journal, and will contribute to my qualification as a Clinical Psychologist. As stated above, you will not be identified in any publication.

**Who is organising and funding the research?**

The University of Glasgow and NHS Greater Glasgow & Clyde will organise and fund the research.

**Who has reviewed the study?**

The study has been reviewed by the University of Glasgow to ensure that it meets standards of scientific conduct. It has also been reviewed by NHS Greater Glasgow & Clyde Mental Health Ethics Committee to ensure that it meets standards of ethical conduct.

Thank you very much for reading this information and for any further involvement you may have in the study.

## **APPENDIX 2.6**

### **PARTICIPANT CONSENT FORM**

**Title of Study:** *A Study of Personal Experiences of Psychosis*

**Name of Researcher:** *Beatrice Anderson*

**Contact Address:** *Department of Psychological Medicine  
Academic Centre  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow G12 0XH*

Please Tick Box

1. I confirm that I have read and understood the information sheet about the study dated 21/01/09 (Version 2). ☐
2. I confirm that I have had an opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily. ☐
3. I understand that my participation in the study is voluntary and that I am free to withdraw from the study at any time, without giving any reason, and without my medical care or legal rights being affected. ☐
4. I understand that it may be difficult or upsetting to talk about my experiences of psychosis, and that I will have access to professional support if this is required. ☐
5. I understand that I will be required to meet with the researcher on two separate occasions, for approximately one hour. ☐
6. I understand that my second interview will be tape-recorded, solely for the purposes of the research study described in the Participant Information Sheet dated 21/01/09 (Version 2) ☐
7. I give consent for the researcher, Beatrice Anderson, to contact the doctor involved in my care to confirm my diagnosis. ☐
8. I give consent for the researcher, Beatrice Anderson, to have access to my case notes, solely for the purposes of the research study described in the Participant Information Sheet dated 21/01/09 (Version 2) ☐
9. I give consent for the researcher, Beatrice Anderson, to contact my keyworker in order to ensure that participation in the research will not interfere with my ongoing treatment. ☐
10. I give consent for the researcher, Beatrice Anderson, to use quotations from our conversation in reports about the research. ☐
11. I agree to participate in the above study. ☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person Taking Consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

When completed, original to be kept in case notes. Copies for participant and researcher file.

***Thank you for taking part in the study.***

## **APPENDIX 2.7**

### **SEMI-STRUCTURED INTERVIEW SCHEDULE**

## Interview Script

Text in italics denotes information for the interviewer. Text in bold denotes interview content.

*In general, it is important that the interviewer approach the interview with an inquisitive, warm and open attitude. A non-judgemental and genuinely curious atmosphere promotes honest and uninhibited narrative, and as such is the optimum condition for the interview. The interviewer, at all times, should listen actively, i.e. nod, lean in, and make affirmative noises. Furthermore, the interviewer should reflect back to the individual, but without introducing new material to the dialogue. This will have the effect of confirming understanding, clarifying stances, underlining salient points and, importantly, offer the individual a chance to collaborate with the interviewer. For example, a participant may disagree with the interviewer's reflection, but collaborate with them effectively by trying to explain themselves in an alternative manner.*

*The interview should be approached in a sensitive manner, which does not presume to make meaning of the person's experiences. Medical terminology should be avoided (illness, psychosis) such that the individual may describe their experiences using the language and perspective they choose for themselves. This may be achieved by explaining in session one that we are interested in the experiences that led the person to become involved with services, and how they have come to understand these experiences, up to the present time. Again, reference to 'recovery' should not be made explicitly, as it remains for the individual to identify themselves as 'recovered', 'in recovery', etc.*

*We are interested not only in the 'gestalt' of the experience, but also in the details that were salient to the individual. As such, it makes sense to start wide and pull in the net gradually. This will be the flavour of the entire interview, i.e. the net will be thrown wide, allowing the individual the opportunity to spontaneously initiate discourse and reflection around their experiences. Should the individual not spontaneously offer reflections on experiences, demand probes will be introduced.*

*After initial conversation to ease in to interview...*

**So, [John], last time we met I explained to you that we are interested in the experiences you've had that led you to come in to contact with [the mental health team] and how you have made sense of what has happened to you.**

- 1. I wondered if you could start by giving me an overall summary of those experiences, starting with what led you to come in to contact with [the mental health team]. You don't need to go in to too much detail – we'll talk about the times that were especially important to you in a moment.**

*This question aims to give the interviewer a general impression of what experiences the individual has been through. The individual is likely to start introducing their own, idiosyncratic terminology at this point, and it is important that the interviewer makes note of this and incorporates it into his/her own language. Responses to this question may also provide 'sound bite' information about the individual's perspective: "it was terrible", "I was terrified", "my family were supportive", "the staff didn't believe me", etc.*

*The individual may be provided with one or two prompts to the original question, should they become overly loquacious around a particular event, etc. The prompt should take the form of:*

- **That sounds like a particularly important memory, and I'd like to hear some more about it in a moment. Would you mind telling me the overall summary of events first?**

*The interviewer must be prepared for a complex story, which may include several twists and turns. Notes should be made as the individual recounts his/her story, as an aide-memoire. It may be helpful to have a pre-prepared timeline in order to jot down events.*

2. **Okay, thanks for that. Now I'd like us to talk about specific events or times in that period you just told me about that were particularly important to you. Could you tell me about two or three of the most important times? Take your time.**

*Interviewer should make notes of responses to this question. This question is designed to give the individual an opportunity to begin populating their own story, i.e. recognising their ownership of the experiences. In particular, care has been taken to keep the question neutral and non-judgemental. By way of example, an individual might identify that the times that were most salient to them were when they were detained in hospital, and when they began a depot medication. The interviewer is looking for spontaneous reflections on WHY certain 'chapters' of the story were salient, and how the individual FELT about experiences.*

*The individual should be given sufficient time to expand their reflections spontaneously. This should include providing participants with time to gather their thoughts. Long pauses should be tolerated, but clinical judgement will be required to ascertain whether the individual is becoming stuck and the interview should progress. Should the individual reach a point where narrative stalls, or becomes irrelevant/tangential, or continues to be meticulously detailed but without reflection, then the following probes should be introduced as required:*

- **Possibly times that really made you think, or that made you feel very strongly?**
- **Elaboration/refocusing questions: what happened then? Who was there?**
- **What was it about the experience [of going into hospital] that made it important for you?**
- **What did the experience make you think?**
- **What did the experience mean to you?**
- **How did the experience [of starting depot medication] make you feel?**

*We are interested in how the individual reflects upon their experiences. No probe should be given unless the individual has been given reasonable opportunity to spontaneously elaborate or reflect. Elaboration/refocusing questions may be used to guide conversation and keep the individual focused. Reflection questions should be used as appropriate (rather than necessarily in the order given above) in the event that a purely descriptive account has been provided and the individual is preparing to close down the topic, or becomes tangential, etc.*



*One aim of the interviewer is to unpick the individual's sense of agency in their own story, e.g. whether they identify themselves as a victim or director of their experiences. The individual is offered the opportunity to reflect on their own role in how the story unfolded.*

### **3. Looking back now, what do you make of these experiences?**

*This taps in to the meaning-making process, and opens up discourse on how the individual has made sense of their experiences, or 'integrated' them. The question is deliberately sparse, offering the individual the chance to interpret their experiences and impose meaning upon them. For example, an individual may feel that their experiences were punishment for past misdemeanours, or they may reflect upon how childhood experiences impacted upon their adult experiences, etc.*

### **4. (You've already mentioned some people, like Jane, James and Dr Smith). During the time we've been talking about [give time anchors if possible, e.g. from April 1995 to June 2003], were there particular people or relationships that were important to you, in a positive or a negative sense?**

*In this section, we offer the individual an opportunity to talk about and reflect upon their relationships. They are given free rein to paint portraits of the people who have been important to them, and we are interested in how they present the overall flavour of the relationship (good, bad, indifferent, etc), their sense of agency in the relationship (power differentials) and how they reflect on the mental states of others. Should it be required, the following prompts may be used:*

- **Elaboration/refocusing questions: what happened then? Who was there?**
- **How did [Jane] act or react when X [important events] happened to you?**
- **Why do you think [Jane] responded in that way?**

*In discussing the impact of experiences on their relationships, we hope to gather information about the individual's ability to recognise circularity, i.e. how they impact upon others and how others impact upon them. The individual may automatically present information about how their relationships have changed as a result of their experiences. The next section of the interview will also be concerned with how things have changed over time.*

### **5. Okay, moving on now: I've heard about what you thought and how you felt at the time of these experiences, and I'm interested to hear how you think things have changed since that time?**

*Here we are asking the individual to distinguish between then and now, and to reflect upon how their experiences have been formative. The individual may reflect upon how relationships have changed, or how their interpretations of events have changed, etc. The following probes may be used:*

- **What do you think has helped you?**
- **What do you think has hindered you, or held you back?**

- **What do you think you have learned from your experiences?**

*Look for internal and external mechanisms of change.*

6. **Thank you for telling me your story today, and for reflecting on how your experiences have affected you. Just to finish off, could you tell me how you feel about your life now, and about the future?**

*The purpose of this question is to encourage discourse around how and where the individual sees themselves in a recovery process. It is possible that the recovery concept will be rejected, and this can be explored. However, some individuals may identify themselves as fully ‘recovered’, ‘recovering’ or ‘still unwell’, etc. We particularly want to explore the meanings that individuals attribute to these words. Probes may be helpful, such as:*

- **Sometimes, people talk about ‘recovering’, ‘moving on’, ‘being stuck’, etc. How does that apply to you?**
- **What do you mean by [“still feeling terrible”, “recovering”, “recovered”, etc]? Can you describe what that feels like?**

## **APPENDIX 2.8**

### **MAJOR RESEARCH PROPOSAL**

**Understanding Recovery from Psychosis**

**Developing a Recovery Narrative Scale**

## Abstract

**Background:** Traditional accounts of recovery from psychosis have failed to consider the individual's subjective experience. It has been suggested that individuals may vary in 'recovery style': a predominant manner of reacting to experiences. Personal narratives provide an insight in to how individuals process and assign meaning to their experiences, and thus their recovery style. **Aims:** The present study aims to obtain personal narratives relating to recovery from psychosis, and based on these, to develop a means of coding recovery style. The study also aims to obtain preliminary data on the reliability of this coding system. **Method:** A sample of 8-20 individuals who have experienced psychosis will be recruited. After providing informed consent, participants will be interviewed using an in-depth semi-structured interview. All interviews will be transcribed verbatim, with personal identifiers removed to preserve confidentiality. Narratives will be analysed for content and form, and a coding system will be developed based on this. The coding system will be informed by narrative-based approaches to reflexivity and mentalisation. Inter-rater reliability will be established using independent raters. **Applications:** This study will provide preliminary data attesting to the reliability of a Recovery Narrative Coding Frame. This will provide the basis for further research into psychotherapeutic processes of recovery from psychosis, and will inform development of psychotherapeutic strategies to support recovery.

## Introduction

Traditional psychiatric conceptualisations of recovery from psychosis have been criticised for neglecting to consider the individual's subjective experience and perspectives (Roberts, 2000). Outcome research has relied upon measures of occupational and symptomatic change, but there is evidence that these fail to describe recovery following psychosis fully. For example, Liberman, Kopelowicz and Ventura (2002) demonstrated that clinical symptoms may not improve in parallel with social and functional aspects of recovery. A recent document by the Scottish Recovery Network (*Recovering Mental Health in Scotland*; Scottish Recovery Network, 2007) attempted to enhance understanding of recovery through consultation with mental health service users about what they found helpful or unhelpful during the recovery process. A number of recovery-congruent factors emerged, including the development of positive self-regard and hope for the future, having meaningful activity and purpose in life, having contributions and choices validated and valued, having supportive relationships, and having the right combination of treatments and support (Scottish Recovery Network, 2007).

Thus, outcomes valued by service users may not be described by occupational or symptomatic outcomes alone.

A crucial aspect of recovery from psychosis is how individuals respond to and cope with experiences. Just as there are differential clinical outcomes following psychosis, so have heterogeneous psychological and behavioural responses been observed. These responses have been conceptualised by some (e.g. McGlashan, Levy & Carpenter, 1975) as an analogue of the individual's wider 'recovery style' – an enduring and static set of psychological and behavioural reactions to significant events. McGlashan *et al.* (1975) distinguished two categories of recovery style: 'integrative' and 'sealing-over'. It is hypothesised that an 'integrative' recovery style is characterised by some level of curiosity and interest in one's own experiences, reflecting a drive to understand these experiences in the wider life context. In contrast to this, a 'sealing-over' recovery style is hypothesised to serve the function of dismissing or barring experiences from consciousness, and is manifest in refusal or inability to reflect upon experiences.

In one study of individuals recovering from psychosis, those identified as having a 'sealing-over' recovery style were rated by mental health workers as demonstrating lower levels of help-seeking, treatment adherence, and collaboration with services than those with 'integrative' or mixed recovery styles. Such individuals described themselves as having lower self-esteem, greater sensitivity to criticism and rejection in relationships, and having had less caring and more controlling early parental relationships (Tait, Birchwood & Trower, 2003). Therefore, recovery style may be analogous to an interpersonal stance or response style, rooted in early attachment experiences. This style may be reflected in discourse about experiences, and strategies employed in processing and contextualising experiences (e.g. adopting an open, curious stance, or a closed, defensive stance). This can be considered the individual's 'narrative strategy'.

In recent years, researchers have become increasingly interested in personal narratives: the unique stories constructed by an individual to describe and explain life experiences (Morgan, 2000). It is proposed that the process of narrative production is used to process and assign meaning to experiences. This is in keeping with social-constructionist theories, which identify language and meaning-making processes as vital in the creation of personal and social identities. An individual's life is conceptualised as multi-storied, with the potential to create alternative narratives around a single event. It has been proposed that experiences are organised hierarchically, and that events that fit a dominant plot, or 'core narrative' are more closely attended to (Ridgway, 2001). Over time, the core narrative gains richness and supersedes other

events, which may be overlooked or forgotten. In particular, Roberts (1999) has emphasised the importance of finding meaning in suffering.

There is some evidence that narratives and narrative strategy may evolve over time; for example, Tait *et al.* (2003) suggest that there may be adaptability in an individual's predominant responses during the period following a psychotic episode. Lysaker (2005) comments, *'if one's story about self and disorder is an organising force behind how people think and converse about their lives, elicit support and evolve a realistic sense of what can and cannot be done, narrative may be conceptualised as an outcome in itself'* (p.407). Core narratives have been shown to become more dynamic and complex over the course of recovery from serious mental illness (Ridgway, 2001).

Given the importance of narrative processes in making sense of experience, it is proposed that personal narratives may provide an insight into processes of recovery and adaptation following psychosis. An important finding is that, in individuals who have experienced psychosis, narratives or narrative processes may be 'deficient' or disrupted. Lysaker, Wickett and Davis (2005) and Lysaker and Buck (2007) found narrative 'deficits' in individuals with a diagnosis of schizophrenia, with narratives being comparatively sparse and lacking agency, possibly underpinned by problems in 'reflexivity'. Reflexivity may be defined as *'subjective awareness and explicit articulation of private mental experience'* (Dilks, Tasker & Wren, 2008). Impairments in reflexivity have been associated with greater difficulty following psychotic experiences, such as deficits in working memory, greater likelihood of negative symptoms and thought disorder, poorer social functioning, greater suspiciousness and more hallucinations (Lysaker *et al.*, 2005; Lysaker & Buck, 2007).

The capacity to talk cogently and coherently about oneself and one's difficult experiences is understood as an outcome of attachment security. The response of an individual to perceived attachment-related threat and trauma, parental relationships, separation and loss is of particular interest. This may be ascertained using the Adult Attachment Interview (AAI; Main, Goldwyn & Hesse, 2002). Holmes (2001) has suggested that the ability to construct coherent and collaborative narratives is a feature of psychological resilience, or a 'psychological immune system' that provides protection against future trauma and adversity.

The construction of coherent personal narratives also depends upon the individual's capacity to reflect upon the mental states of him- or herself and others, and to utilise this knowledge to solve problems, negotiate transitions or adapt to stressful life events. This requires

‘mentalisation’: the recognition that experiences evoke beliefs and emotions in oneself and others, and that certain beliefs and emotions are likely to result in corresponding behaviours (Fonagy, Gergely, Jurist & Target, 2002). An intentional stance, mentalisation is a developmental competency which is essential in the creation of a consistent self-experience, which in turn leads to coherent self-structure. The development of secure attachment includes construction of a contingency between the experience of distress and relief of that distress via the attuned intervention of an attachment figure. This, in turn, leads to the precocious development of mentalisation (Meins, Fernyhough, Russell & Clark-Carter, 1998). As such, robust mentalisation can be understood as being optimally established in the context of secure attachment, and is reflected in adulthood through coherent narratives.

The concept of mentalisation incorporates ‘theory of mind’: the ability to differentiate between the mental states of oneself and others. Sprong, Schothorst, Vos, Hox & van Engeland (2007) found that theory of mind was ‘impaired’ in individuals with a diagnosis of schizophrenia, compared to non-clinical controls, and that this continued in to symptomatic remission. Holmes (2001) has argued that failure of self-other differentiation may be observed in psychotic experiences such as paranoia (attribution of malevolent thoughts to others), thought insertion and withdrawal (failure to distinguish and source one’s own thoughts from others’) and thought disorder (where self-other differentiation becomes compromised). Such experiences can leave a person feeling frightened and vulnerable. In this context, emotional responses (e.g. fear, anger and hopelessness) and affect dysregulation may be conceptualised as outcomes of psychotic experiences.

Gumley, Schwannauer, Macbeth and Read (2008) have argued that narrative coherence can be understood as an outcome of attachment-related experience, and reflects capacity for cognitive and emotional regulation, especially in the face of distressing events involving threat, trauma, separation and loss (Bowlby, 1969, 1973, 1980). Related to psychosis, they propose that narrative coherence may provide insight in to:

- a) Individual responses to psychosis and its sequelae;
- b) The developmental and interpersonal roots of adjustment;
- c) Underlying processes of cognitive and affective regulation, embodied in reflexivity;
- d) Core tasks of psychotherapeutic change.

Narrative is described by some as a “root metaphor” for psychology (Machado & Goncalves, 1999). In therapy, the greater an individual’s ability to generate narrative, the greater the

therapist's opportunity successfully to attune and respond to him or her (Angus, 1990). Crucially, narrative form and coherence in the context of recovery from psychosis provide a framework for a developmentally-grounded conceptualisation of the individual's response to painful and distressing experiences. Narratives thus provide an insight into vulnerability and resilience in the face of psychotic experiences. Therefore, this study aims to develop a method by which to code the narratives of individuals reflecting upon their experiences of psychosis. Such a coding system would support the development of a narrative-based approach to evaluating recovery and adaptation following psychosis.

## **Aims**

- To obtain narratives of service users' perspectives and experiences of recovery using a semi-structured interview;
- To explore the form and content of these recovery-related narratives;
- On the basis of this, to develop a coding system that describes the nature and form of recovery-related narratives;
- To conduct preliminary evaluation of the inter-rater reliability and construct validity of Recovery Narrative Coding System.

## **Plan of Investigation**

### Participants

Participants will be individuals who have experienced an affective or non-affective psychosis as diagnosed by their Responsible Medical Officer (RMO) and verified by examination of case notes. Participants will be required to consent voluntarily to participation in the study.

Participants will be males and females over 16 years old. Information about medication, educational level, current or previous involvement with psychotherapy and additional diagnoses (psychiatric comorbidities) will be gathered from case notes and clinical interview, in order that confounding effects may be given due consideration.

### Exclusion Criteria

- History of significant head injury – determined by case notes and interview
- Organic aetiology of psychosis (e.g. HIV) – determined by RMO



- Learning disability – determined by case notes and RMO
- English as a second language – determined by case notes and interview
- Current acute-phase psychosis – determined by RMO

### Recruitment Procedures

A sample of 8-20 participants will be recruited from the rehabilitation wards of Gartnavel Royal Hospital, the inpatient wards of Dykebar Hospital and from Esteem South, an early intervention service for psychosis (all NHS Greater Glasgow and Clyde). Meetings will be arranged to provide service staff with information about the study and its aims. Following this, advertisements and information packs (see Appendix) will be placed in reception areas. The advertisement will include a brief description of the study, with a tear-off slip and a stamped, addressed envelope for individuals who are interested in participation. Individuals will be invited, on a voluntary basis, to contact the Chief Investigator if interested in participation, by completing the tear-off slip and returning it in the envelope provided.

Individuals returning the tear-off slip will be contacted by telephone by the Chief Investigator. They will be provided with information about participation in the study, and will have the opportunity to ask questions. Those who wish to participate will be asked to consent to the Chief Investigator contacting their key worker to ensure that participation in the study is unlikely to impede any ongoing treatment. If this is ascertained, then the individual will be invited to an initial session at the base of the mental health service with which they are involved. Further sessions will be arranged forthwith.

### Tools/Measures

#### *Narrative Interview Schedule* (see Appendix)

This semi-structured interview has been designed by the research team to stimulate narrative around experiences of mental ill health and recovery. It is based on a synthesis of theories about narratives, as referred to in the introduction section. The interview aims to open up dialogue about experiences, offering the individual an opportunity to discuss collaboratively and reflect upon experiences, and becoming progressively more demanding of the individual to demonstrate skills in reflexivity and narrative production (a ‘funnel structure’). Dialogue will be built on a framework of six core ‘open’ questions, with ‘demand’ prompts where necessary. The interview will take approximately one hour to administer.

### *Narrative Interview Coding System*

A manualised coding system will be developed to systematically analyse narratives transcribed from the Narrative Interview Schedule. The coding system will consider collaborative discourse and mentalisation. Collaboration in dialogue may be evaluated utilising Grice's (1975) maxims. In order to explain how non-literal narrative is understood, Grice proposed that a 'cooperative principle' exists in verbal communication, manifested in the existence of certain 'maxims' of conversation. These may be conceived as '*presumptions about utterances that we as listeners rely on and as speakers exploit*' (Bach, 2006). Grice (1975) contends that contributions to conversation are normally dictated by the specific requirements of the situation in which they occur, and that utterances are normally expected, as far as possible, to be truthful, appropriately informative, relevant and clear. Overly sparse and excessively detailed narratives, for example, may both be associated with poorer outcomes, and have been linked to insecure attachment styles (Holmes, 2001). Reflection on self/other mental states will also be assessed. The coding system will consider not only the topics covered by narratives (e.g. mental states of self and others, temporal change in self-percept, etc.) but also the spontaneity with which reflection occurs, the richness of the narrative, and the associations between these factors. It will also aim to characterise the overall narrative strategy. The coding system will contain scales, on which an individual's capacity in specific spheres (e.g. spontaneity of reflection, consideration of own mental state, etc.) may be placed according to the narrative procured using the Narrative Interview Schedule.

### Research Design

This research will use qualitative methodologies, in which the narratives are analysed using both a Grounded Theory approach and a Narrative Analysis paradigm. This will provide the basis for developing a coding system, with the system then being applied across all transcripts of recovery-related narratives yielded from participants. At least three analysts will independently read transcripts. A constant-comparative method (Glaser & Strauss, 1967) will be used to make comparisons between and within interviews at all stages of analysis.

### Research Procedures

On the basis of the literature, the Chief Investigator and Academic Supervisor have developed a semi-structured interview that aims to stimulate narrative around the experience of mental ill health and recovery. Of specific interest are the individual's memories, reflections about mental states of self and others, meaning-making processes and attitudes about the past, present and

future. This interview will be used to yield recovery-related narratives, which will constitute units of analysis. All interviews will be transcribed by the Chief Investigator, who has experience of transcribing clinical interviews for research purposes.

Prior to conducting sessions with participants, the Chief Investigator will conduct a case-note review (with participant consent). The Chief Investigator will meet with each participant on two occasions:

- **Session 1** – introductory session; includes orientation, rapport-building, and opportunity to obtain outstanding information (e.g. demographics, education level).
- **Session 2** – semi-structured interview will be used to obtain the participants' narratives of their experiences.

Every participant will also be offered an optional further session. This will ensure that any outstanding issues may be resolved prior to conclusion of contact. When the study is complete, participants will be provided with a written summary of findings.

#### Justification of Sample Size

Due to the qualitative nature of the present study, it is not possible to perform a power calculation to determine sample size. Turpin *et al.* (1997) have suggested that a sample of 8-20 participants is desirable for qualitative research conducted as part of a Doctorate in Clinical Psychology. It is hoped that a sample of this size will be sufficient to yield meaningful data (i.e. to reach thematic saturation). Data collection will end when no themes or ideas that cannot be coded using the Narrative Coding System arise during interviews. This will be subject to ongoing review, and further participants sought as necessary.

#### Settings and Equipment

All sessions will be conducted on the premises of the mental health service with which the participant is involved (NHS Greater Glasgow & Clyde).

The following equipment will be required:

- A digital recording device, with which to record sessions
- Personal safety alarm

## Data Analysis

Data (transcripts) will be analysed in two parallel phases:

### *Grounded Theory Analysis:*

The content of data will be analysed using methods derived from Grounded Theory (Charmaz, 2006). This phase of analysis will enable the researcher to remain open to exploring theoretical possibilities arising from the data. Specifically, initial coding will describe the data using line by line micro-codes. These initial codes will be provisional, comparative and grounded. Through a process of re-reading transcripts and comparing and contrasting categories, focused codes will then be established. Focused codes will enable the development of analytic direction as line by line codes become subject to increasing synthesis and conceptualisation. Again, constant-comparative methods will be used to make comparisons between and within interviews at each stage of analysis. In this way, the Chief Investigator (BA) will develop a thorough understanding of the narratives produced by the Narrative Interview Schedule.

### *Narrative Based Analysis:*

In parallel to Grounded Theory analysis, the format of discourse within the transcripts will be subjected to a narrative-based analysis by the Academic Supervisor (AG). This analysis will focus on (a) the speaker's capacity to adhere to Grice's maxims of rational cooperative discourse (collaboration and coherence) and (b) mentalisation (evidence of the speaker's attention to his or her own and others' mental states, and the utilisation of mental state information to make sense of own or others' behaviour, feelings or responses). The coding for this will be initially derived from the Reflective Functioning Manual for Application to Adult Attachment Interviews, Version Five (Fonagy, Target, Steele & Steele, 1998) and the analytic process will enable the evaluation of existing categories of mentalisation (as contained in the Reflective Functioning Manual), and the identification of additional categories of mentalisation.

### *Data Synthesis:*

Adequacy of data analysis and synthesis between the two analytic approaches will be supported using N-Vivo (QSR International, 2008). The use of constant-comparative methodology between codes developed in parallel will enable the development of a theoretical coding structure which will build on focused codes derived in the Grounded Theory Analysis and thus will specify possible relationships between categories developed from the focused codes,

enabling their integration into a theoretical conceptualisation of the data. On the basis of this, the Recovery Narrative Coding System will be developed.

In order to assess the internal reliability of the scale, several raters will use the manualised coding system to assess narrative transcripts. At least one of these raters will be independent of the research team. Inter-rater reliability will be analysed using Cohen's Kappa Coefficient (Cohen, 1960).

### **Health & Safety Issues**

Each participant will be interviewed individually by the Chief Investigator. Recovery interviews will take place on the premises of the mental health service with which the participant is involved. There will be no home visits. Each site at which interviews take place will be assessed separately in terms of health and safety issues, and arrangements will be overseen by the local field supervisor. Health and safety arrangements will be agreed with the management of each mental health service prior to commencement of research. During research sessions, at least one other mental health professional will be on the premises at all times. Both researcher and participant will have access to facilities and will be made aware of safety procedures.

The participant will be made aware of their right to withdraw from participation at any time. All participants will have the opportunity to discuss their experience of participation and debrief with the researcher. Should it be required, the participant will have the opportunity to access a mental health professional following sessions with the researcher. The researcher will have access to a personal safety alarm. Should it be required, the researcher will have the opportunity to debrief with an Academic Supervisor following sessions with participants.

### **Ethical Issues**

- Ethical approval will be sought from the local Research Ethics Committee.
- A plain-language consent form will provide details of the study and will require participants to give voluntary, written consent to involvement. In order to avoid coercion, the form will clearly state that participants are consenting voluntarily to involvement and can withdraw at any time without this affecting treatment.

- In order to ensure that consent is fully informed, individuals in the acute phase of psychosis, individuals with learning disability and those with a previous head injury will be excluded.
- The nature of the current study may require participants to discuss potentially distressing material. The written consent form will clearly delineate this risk to participants, and emphasise participants' right to withdraw from the study at any time.
- In order to ensure that participants have an opportunity to debrief following the recovery-related interview, a third session will be offered, during which the experience of participation may be discussed with the Chief Investigator.
- If issues are raised in sessions that require follow-up or invoke a duty of care, then participants will have access to appropriate professional care. The researcher will also be trained in managing distress and/or emotional arousal.
- A brief summary of sessions will be recorded in participants' case notes at the mental health service with which they are associated. Should information be raised during sessions that has not been shared with the mental health service, then consent will be sought to share this information, and information will be confidential unless consent is provided.
- Data will be anonymised by removal of personal identifiers and/or identifying details. This will be given special consideration when reporting excerpts of narratives. Participants will be informed of the right to confidentiality and how this will be upheld. Audio tapes will be converted to digital transcripts using Microsoft Word 2007. Audio tapes will then be destroyed, and digital files stored on a password-protected computer.

## Financial Outlay

Item to be purchased	Cost
Digital Voice Recorder	£50.00
Administrative Costs:	
• Paper	£5.00
• Envelopes	£5.00
• Stamps (30x large first class @ 52p)	£16.64
• Photocopying	-
Participant Travel Expenses*	
• £5 per participant	£40-100
Researcher Travel Expenses	NHS mileage rate
<b>TOTAL</b>	<b>£176.64 + Researcher Travel Expenses</b>

\* Participant travel expenses – participants will be reimbursed for travel to and from research sessions, as these do not constitute part of their normal treatment plan.

## **Timetable**

Jan 2008	Begin recruitment, interviews, transcription, and analysis. Refine coding system.
Apr 2009	Begin write-up.
May 2009	Draft submission.
Jul 2009	Final submission.

## **Practical Applications**

Potentially, this research will benefit multiple stakeholders, by:

1. Contributing to the development of a framework by which narratives may be coded to assist in the recognition and formulation of recovery processes;
2. Improving understanding of the emotional and metacognitive sequelae of psychosis and how these may be inter-linked;
3. Assisting identification of psychological needs of individuals with psychosis, consistent with NHS Quality Improvement Scotland guidelines for schizophrenia (NHS Clinical Standards Board for Scotland, 2001);
4. Adding to theories of narratives and recovery;
5. Synthesising research on narratives and recovery;
6. Contributing to the development of psychological therapies that address – or are responsive to – an individual’s specific narrative profile, and which facilitate narrative formation and stimulate recovery-congruent processes.

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